WASTE AND INEQUITY: A CALL FOR IMPROVED MANAGEMENT OF MEDICARE'S PRIVATE INSURANCE CONTRACTORS

Y 4. SM 1: 103-112

Waste and Inequity: A Call for Impr...

HEARING

BEFORE THE

SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND TECHNOLOGY

OF THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

WASHINGTON, DC, DECEMBER 19, 1994

Printed for the use of the Committee on Small Business

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WASTE AND INEQUITY: A CALL FOR IMPROVED MANAGEMENT OF MEDICARE'S PRIVATE INSURANCE CONTRACTORS

MONDAY, DECEMBER 19, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES, AND TECHNOLOGY,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 2237, Rayburn House Office Building, Hon. Ron Wyden (chairman of the subcommittee) presiding.

Chairman WYDEN. The subcommittee will come to order.

Today, the Subcommittee on Regulation, Business Opportunities, and Technology continues its investigation into the peculiar ways in which Medicare pays doctor bills for the Nation's senior citizens.

The General Accounting Office has been researching this issue at the request of the subcommittee and will report their findings today. This report, which examines the Government's lack of control over the Medicare claims payment process, has direct consequences for small businesses and their retirees. Millions of small businesses lack retiree health benefits, and thus their workers are dependent solely on Medicare to meet their health insurance needs.

The first oddity encountered by retirees on Medicare, after they leave the doctor's office, is that they find Medicare is not the national program they think it is. When their doctor sends in a bill to Medicare, it doesn't go to the Federal Government, but goes instead to a private insurance company. Because the Federal Government has given private companies the authority to determine how or whether to pay doctor bills, Medicare is now a crazy quilt of separate and dramatically different programs run by more than 30 private insurance companies.

Under Medicare law, one of the most important jobs these private insurers are supposed to perform for the taxpayers is to check claims to be sure the services billed by the physician were medically necessary. But the General Accounting Office will report today that they have found evidence that most doctor bills are simply paid before medical necessity is verified. This is true of even the 74 most costly Medicare services which were the subject of the General Accounting Office's investigation.

Paying claims without first verifying medical necessity is bad news for our taxpayers and for the Nation's elderly. Medicare's $60 billion doctor-payment program is funded 75 percent by taxpayers

and 25 percent by premiums paid by seniors with Medicare. When medically unnecessary claims are paid, both the Federal deficit and Medicare premiums keep soaring.

Paying medically unnecessary claims can be hard on senior citizens in two additional ways. First, doctors who provide services that are unnecessary are supposed to be held liable for the bills. However, many doctors demand a written promise of full payment from older people before providing the service. If the service is later deemed to be unnecessary, the patients must pay or attempt to get their doctor to give them a refund. In addition, older people can be physically harmed by unnecessary surgery and medical procedures.

Now, the Secretary has found that there is more unpleasant news for older people concerning the small number of claims that do get checked for medical necessity. The private insurance companies that make up the little-known private Medicare bureaucracy get to make their own rules as to which Medicare claims are paid.

This free-lance approach to Medicare management has produced an astonishing degree of inequity for older people served by different carriers. For example, the new analysis shows extraordinary differences in insurance carrier payment practices. For example, for chest X-rays, the medical necessity denial rate by the carrier serving Illinois was 900 times the denial rate by the carrier serving the adjacent State of Wisconsin. For a set of laboratory tests, the medical necessity denial rate by the carrier serving Illinois was nearly 1,400 times the denial rate by the carrier serving northern California. For a radiologist's study of arteries, the medical necessity denial rate by the carrier serving southern California was 175 times the denial rate by the carrier serving North Carolina.

These dramatic differences in claims denial rates were consistent with the findings in last year's GAO report which found that in 1992, an older woman whose physician prescribes a diagnostic mammography to detect breast cancer is 180 times more likely to have Medicare deny payment for the mammography if she lives in southern California than if she lives in northern California. A one-way ambulance ride in Illinois is almost always paid for, but a claim for the same trip in southern California is 740 times more likely to be denied.

In 1992, the General Accounting Office found that the Medicare contractor in Illinois is 500 times more likely to deny payment for a chest X-ray than is the South Carolina carrier.

Last year, one of the largest of these private Medicare insurance contractors responded to the findings of the General Accounting Office by telling news reporters that their guidelines for medical need were prepared, and I quote, "within the policies set by the Health Care Financing Administration." Shortly thereafter, that same carrier undertook an in-depth study of its own denial practices compared to those of other carriers.

Their study, which I will include for the official record, offers independent confirmation of the General Accounting Office's findings: The Health Care Financing Administration in fact, provides far too little guidance to the private Medicare carriers. For the Nation's elderly, this translates into far too little accountability.

The Government's loose reins on these private insurance contractors has produced a program in which Medicare doesn't pay claims

that should be paid, Medicare pays claims that ought to be denied, and does not have a systematic approach to knowing the difference.

It doesn't take much imagination to see what will happen in 5 years if private insurers get more money to scrutinize claims and no one simultaneously insists on more accountability and uniformity among the carriers. They'll do what insurance companies do naturally, come up with more secret rules enforced on doctors and elderly patients by faceless and unaccountable private-sector bureaucrats.

Under this nightmare scenario for the late 1990's, even those who today counsel Congress to ignore inequitable denial rates will have to acknowledge that these problems documented by the GAO back in 1992 should have been heeded.

The simple truth is that Medicare inequities will only get greater when carriers really begin to do their job checking claims when 25 percent of the claims are checked instead of this year's 5 percent. It will become impossible to ignore the wildly varying denial rates of Medicare carriers. It is hard to see the advantage of waiting for this to happen, especially when most of the inappropriate services are rendered by about 5 percent of the doctors.

To come up with a more thoughtful approach, it's useful to take a moment to look at what the General Accounting Office said for the four reasons behind the very large discrepancies between carriers.

The GAO found that Medicare's private insurance company contractors are each permitted to develop their own lists of medically unnecessary services lists, which are unknown and inaccessible to most of the doctors and patients. These lists vary significantly in the ailments with doctors are allowed to treat with a given medical procedure. Some carriers check claims for a given service for medical necessity before paying the claims, while other carriers check none of the claims before payment.

The General Accounting Office found that when the Health Care Financing Administration does occasionally issue a national guideline to all of the insurance carriers, defining when a service is to be regarded as medically necessary, vagueness in these guidelines has often led to differing interpretations by the carriers.

The General Accounting Office finally found that carriers handle incomplete claims in different ways, with some carriers immediately denying payment while other carriers contact providers for the missing information and pay the claim; and a particular carrier may give surgeons a second chance to correct incomplete claims while the same carrier outright denies any incomplete claims submitted by a chiropractor.

The General Accounting Office is going to recommend today that the Health Care Financing Administration tighten its supervision of Medicare privacy insurance contractors. I have a couple of additional ideas that I would hope would be considered for addressing this serious problem.

First, the Health Care Financing Administration should crack down on arbitrariness and inequity by stipulating that whenever there are large variations in carrier denial rates for a particular service, carriers should be required to use national guidelines developed in consultation with the Agency for Health Care Policy and

Research. A carrier would only be permitted not to use these national guidelines if it received a waiver to evaluate alternative medical policies that would be fair to seniors, taxpayers, and providers.

Second, the Health Care Financing Administration should insist that carriers focus on checking the medical necessity of all claims submitted by the 5 to 6 percent of the Nation's physicians that now account for half of medically unnecessary services. It is common sense for carriers to look for overpayments where the inappropriate care is, and to check these claims before they are paid.

The Chair wants to thank our witnesses and, in particular, to express the subcommittee's appreciation to the General Accounting Office for the exceptional service that they have provided in preparing this testimony expeditiously and to the Medicare Beneficiaries Defense Fund for the superb advocacy that they provide to the Nation's seniors. I would like to note that the Health Care Financing Administration has been very forthcoming in terms of discussing these matters with the subcommittee.

So, with that, let us begin with our first panel, Dr. Terry Hedrick, Assistant Comptroller General, Program Evaluation and Methodology Division, U.S. General Accounting Office.

Let us—Dr. Hedrick, so we can go to the formalities, you have with you—why don't you identify for the record the people who will be with you?

Ms. HEDRICK. I have on my left Dr. Sushil Sharma, who has been the Assistant Director in the Program Evaluation Division for this body of work. I have on my right Thomas Dowdal, who is the Assistant Director in the Health Education and Human Services Division.

I also have with me, sitting behind, Rich Lipinski, the Project Manager, and Kwai Chan, the Issue Area Director for this area.

Chairman WYDEN. Do you anticipate Dr. Sharma and your associates responding to some of the questions?

Ms. HEDRICK. Yes, that would be fine.

Chairman WYDEN. It is the practice of this subcommittee to swear all the witnesses who come before us. Do you have any objection, any of you three, to being sworn as a witness?

Please rise and raise your right hand.

[Witnesses sworn.]

Chairman WYDEN. We are going to make your testimony a part of the record.

Dr. Hedrick, before we begin, though, I do want to extend special appreciation to Dr. Sharma, who in my view has done yeoman service on this project. He has worked very, very hard on this project and closely with us. I know that Mr. Lipinski is here with us as well, who in my view has also performed very well for the Agency; and I understand some of their supervisors are here as well. So, we thank you, and we are going to make your prepared statement a part of the hearing for the record in its entirety; and why don't you please proceed.

TESTIMONY OF DR. TERRY E. HEDRICK, ASSISTANT COMPTROLLER GENERAL, PROGRAM EVALUATION AND METHODOLOGY DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. HEDRICK. Thank you very much.

My statement today is based on our report Medicare Part B: Regional Variation in Denial Rates for Medical Necessity, and that report is being issued today. Our report has two objectives: To determine the extent of variability in service claim denial rates for lack of medical necessity across Medicare carriers; and two, to identify and examine five factors that may contribute to this variation.

The carriers we included in this study were California Blue Shield, which covers northern California; Transamerica, which covers southern California; Connecticut General Life Insurance Company, covering North Carolina; Blue Shield of South Carolina; Illinois Blue Cross and Blue Shield and Wisconsin Physicians' Service. In the interest of time, I will not describe in detail the background and operations of the Medicare Part B Program, but will instead move on to the specifics of our analysis and our recommendations.

Medicare carriers are to pay only for health care services that are covered, and they are to reject a claim if they determine that the services were not medically necessary.

In fiscal year 1993, carriers denied 112 million out of 576 million Part B claims in whole or in part for a total of $17 billion denied. Services deemed not medically necessary constituted about 9 percent of this dollar amount.

Now, coverage under Medicare is determined by three criteria: Medicare law, national coverage standards developed by HCFA, the Health Care Financing Administration and local coverage standards developed by individual carriers. In the absence of national coverage standards, HCFA has given carriers the discretion to develop and apply their own medical policies based on local standards of medical practice.

Carriers have broad latitude in this area; that is, that they have primary responsibility for defining the criteria that are used to assess the medical necessity of services. Such local medical policies allow them to target the specific services that may need greater scrutiny.

In response to your request, we analyzed a 5 percent sample of 1992 and 1993 Medicare Part B data on claims processed by these six Medicare carriers for 74 services that were either expensive or heavily utilized. We computed denial rates for services that were determined by carriers to be not medically necessary, using a definition of denial rate as the number of services denied for lack of medical necessity, divided by the number of services allowed, multiplied by 1,000. Let me turn to our results.

To begin with, we examined the magnitude of medical necessity denial rates, the variation across these six carriers and any changes from 1992 to 1993.

Overall, for this group of 74 services, denial rates were generally low, a finding that was consistent across all carriers. Most services had denial rates less than 10 per 1,000 services allowed in 1993. However, some denial rates showed notable differences across the carriers. For example, as you mentioned in your opening statement, the denial rates for a chest X-ray varied between 0.1 and 90.2 per

1,000 service claims allowed. In the latter case, that means that almost 1 chest X-ray was denied for every 10 allowed by the Illinois carrier.

Third, patterns were not unique to a particular year. Services that had high denial rates in 1992 also tended to have high rates in 1993, and the same for low rates.

Now, why is this variation important? We believe that carrier differences in the treatment of claims denied for reason of medical necessity is an important issue because we believe that understanding it better has implications for fostering better management of Medicare expenditures, as well as ensuring the consistency of treatment of providers and of Medicare beneficiaries.

We identified five factors that may help explain the variation in denial rates across carriers. Factor one: Carriers differed in how they implemented computerized prepayment screens.

First, with respect to computerized prepayment screens, we found that the types of services screened for medical necessity varied across the carriers. Although the presence or absence of a screen was not sufficient to account for the variation, it's important to note that the highest denial rates were invariably associated with these screens. Some Medicare carriers used utilization screens, how many visits may occur in a particular time period; some used diagnostic screens; and some used both. Even when carriers screened the same service, they used different criteria at times for suspending claims. For example, they may differ in terms of the nature or timing of when they require additional documentation for visits to a chiropractor exceeding 12.

Factor two, carriers differed in how they interpreted certain national coverage standards. Carriers differed in their interpretations of national coverage standards. Because some standards leave key elements of the policy undefined, they sometimes interpreted and applied the same standards in different ways.

Transamerica, in a 1993 study, found differences across carriers in how they assessed chest X-ray and mammography claims. Carriers had difficulty distinguishing whether these procedures were being performed for screening or diagnostic purposes. Thus, these two area areas, chest X-ray and mammography, were service areas that appeared to be in need of further service clarification by HCFA.

Carriers differed in how they treated incomplete claims. For example, if a carrier's medical policy required that the provider indicate a diagnosis when submitting the claim for a particular type of service and the claim lacked this information, the carrier had several options. They could simply return the claim, they could attempt to "develop" the claim—contact the health care provider and obtain additional information to see whether it should be paid—or they could deny the claim. The option they selected for any given claim depended on factors such as the cost they might incur to spend the time developing it, the capability of their computer system, and any special instructions that they had from HCFA.

Carriers that emphasized claim denial over claim development may have had higher denial rates for medical necessity than others. Now HCFA has examined this issue and is considering eliminating the denial issue for incomplete claims.

Factor number four: Carriers differed in how they reported the reason for a claim denial to the Health Care Financing Administration's central database. To facilitate comparisons between different Medicare carriers, HCFA has required that each carrier translate its own set of internal action codes into 10 broad categories. Transamerica identified two service categories that carriers have tended to use interchangeably: Noncovered care under Medicare and medically unnecessary care.

Our analysis confirms Transamerica's findings. We also found significant intercarrier variability in denial rates whether we looked at noncovered care, lack of medical necessity or the two categories combined. Reporting inconsistencies of this type affect HCFA's ability to accurately monitor program activities.

Finally, factor number five: A few providers account for a significant proportion of the variation in carrier denial rates. We analyzed the 16 services with denial rates above 90 per 1,000 services allowed, and we found that a small minority of providers, between 2 and 11 percent, depending on the service accounted for 50 percent of the services denied for lack of medical necessity, and thus, they were responsible for the bulk of denials. This type of pattern obviously warrants further exploration.

In conclusion, we are not in a position to address the question of whether high or low denial rates for individual service were appropriate. Low denial rates are desirable from the standpoint that they imply less annoyance and inconvenience for health care providers and for Medicare beneficiaries; however, low denial rates are desirable only insofar as providers do not bill for medically unnecessary services.

What is clear from our work is that further analysis of denial rates has the potential to provide insight into how effectively Medicare carriers are managing program dollars and serving beneficiaries and providers. Since the carriers now have funding constraints that limit the number of claims that they can examine on a prepayment basis to 5 percent, it's important that they use the most effective and appropriate screens. We believe HCFA could improve its oversight capabilities by activity monitoring data on carrier denial rates and improving the reliability of the data that it collects.

We have recommended in our report that to improve its oversight of the Medicare B preliminary, HCFA do the following things: Issue instructions to carriers on how to classify the reason for denial when reporting this information; analyze screen usage—computerized screen usage across carriers, including the stringency of the criteria that are used to review the claims; identify effective screens and share this information with carriers; and finally, direct carriers to profile the subpopulation of providers responsible for a disproportionate share of medical necessity denials in order to devise a strategy for this problem.

This concludes my formal remarks.

[Ms. Hedrick's statement may be found in the appendix.]

Chairman WYDEN. Let me begin by touching on this point that I made in my opening statement—and maybe, Dr. Sharma, I'll even address this to you, because I think you have given some helpful information to this subcommittee, and it seems to me you

start with the proposition that in this system Medicare is not paying some claims that ought to be paid, Medicare is paying claims that ought to be denied, and really doesn't have a systematic approach to know the difference.

What would be your reaction to that?

Mr. SHARMA. What is clear from our work is that carriers essentially determine which services they are going to screen for, and if they are going to screen, what criteria are they going to be using; and at the prepayment level, that's the only mechanism they have to approve or deny the claims. We do see some variation across carriers with respect to the types of services they select and screen for, and this is pretty much done at the carrier's level and there are some differences.

Chairman WYDEN. So would you say my description of this is generally accurate?

Mr. SHARMA. Yes.

Chairman WYDEN. I think that's important to note, because, I mean, this is a $60 billion program. The General Accounting Office has been looking at this now for this subcommittee for over 2 years and the more we dig, the harder it is to follow how this program actually addresses the twin needs of the American people.

The American people want to make sure that senior citizens get the benefits they need and deserve. At the same time, taxpayers don't want to get fleeced. As I look at it, now confirmed by Dr. Sharma, it seems to me that there is not a basis in the system to really assess when they're not paying claims that ought to be paid and when they're looking at it in the reverse; and I think this is very troubling, and I think that the Government needs to know how to have a rational system for, in fact, making sure that seniors get a fair shake while at the same time taxpayers don't get fleeced.

My question for you to begin, Dr. Hedrick, is why is it important to look at denial rates of carriers?

Ms. HEDRICK. We believe looking at denial rates is one of the management tools that can be used for the Medicare program. We believe it's important to know what services specific carriers are screening for and what criteria they're using. It allows you to know what kinds of problems are persisting; it allows you to know whether certain carriers are finding certain kinds of screens to be particularly effective and useful; and it meets the accountability needs of the program.

Chairman WYDEN. Under what circumstances do these variations in denial rates warrant additional investigation in your opinion?

Ms. HEDRICK. Well, there are two circumstances. One is that if a lot of providers in an area are being flagged by a screen that a Medicare carrier has, it might be a warning that that policy that is in effect is not reflecting local medical practice and might need to be looked at. It might also be an indication that the provider needs to educate—I am sorry, that the Medicare carrier needs to educate the health care providers in that area about the policy that exists.

The second circumstance in which I think denial rates send up a flag is when you have widely differing denial rates in different parts of the country and that may say that different policies are in effect in different parts of the country. It also may be an indica-

tion that one carrier has found a particularly effective way to screen that should be shared with others.

Chairman WYDEN. Now, about half of the medically unnecessary services seem to be submitted by a pretty small percentage of doctors, something like 5 to 6 percent in your inquiry. Why has the Government been so slow to go after this problem when it seems clear that the focus can be on a relatively small number of doctors? I mean, the message here is that a vast majority of physicians in this country are trying to comply in a responsible sort of fashion, but you have got 5 to 6 percent who clearly are taking this program and the taxpayers for a ride. Yet the Government still doesn't seem to be doing much about that.

Ms. HEDRICK. I think one of the things that you have to do is to have the data at your fingertips to identify those providers when it occurs. That argues again for doing things like monitoring denial rates across providers. When you see a small percentage of providers flagged, it may be an indication that there are problems with fraud and abuse with a limited number of providers. It, again, may also indicate that you need to look at the billing practices and they may be using incorrect codes. So, you have to get behind it to find what's there.

Chairman WYDEN. What's being done to get behind it? I mean, this strikes me as especially troubling. I mean, it would be one thing if we had to deal with 50 percent of the Nation's doctors; but you'd think if you have got a situation where 5 to 6 percent are submitting half the medically unnecessary services, there ought to be a way to get on top of this.

Is this a matter of writing new computer programs to excavate the names of these individuals? What's needed to turn this around?

Ms. HEDRICK. I wanted to make clear that there are some efforts that are ongoing to identify small numbers of providers who are abusing the system. Let me ask Mr. Dowdal to talk to that briefly.

Mr. DOWDAL. HCFA has started some efforts in that area, focused medical review. One of the aspects of that is looking at services that appear to be out of the norm with other areas of the country. Again, as part of that program—that program you could end up looking at a group of people who are responsible for most of the problems.

There have been efforts over the years to do stuff about this to—postpayment review and other things that haven't been extremely successful. Hopefully, the focused medical review will be better at handling the problems.

Chairman WYDEN. Well, do you think what's under way is going to allow for these 5 or 6 percent who seem to be exploiting the program to be rooted out?

Mr. DOWDAL. We believe that it is a better chance than there was in the past. It's too early for us to tell whether it's actually going to work or not.

Chairman WYDEN. My understanding is, to really go after abusers, you have got to have some prepayment review. I mean, aren't we basically trying through a pretty half-hearted kind of a program, without—based on what Dr. Hedrick said, without these computer screens, to play some catch-up ball?

Mr. DOWDAL. One of the aspects, I believe, of the focused medical review is to develop prepayment screens. Obviously, it's better to have a prepayment screen and not pay a claim than to do something after the fact and try and get the money back.

Chairman WYDEN. But these prepayment screens don't exist today?

Mr. DOWDAL. Well, they do, but there aren't a whole lot of them. What we're talking about here in this report are the differences across carriers that are resulting primarily because of the presence or absence of a screen. If one carrier has a screen, and another doesn't, the one that's going to have the higher denial rate is always the one that has the screen.

Chairman WYDEN. What is the Health Care Financing Administration doing, based on your inquiry, as far as the carriers who identify these doctors? I mean, does the Health Care Financing Administration insist that these carriers go after the doctor?

Mr. DOWDAL. They would be in a better position to answer that directly, but I know what they do is they look for services that are out of bounds with the other carriers. They send a list of those services to each carrier, where they are the ones that are out, and then they ask the carriers to develop programs to address any problems that are identified in that list.

Ms. HEDRICK. If I can also add to it, I think it's important to note that the funds available for doing reviews for medical necessity have decreased dramatically from 20 percent to 5 percent of the services being reviewed. So, in 1994, carriers are funded to review only 5 percent of the service claims.

Chairman WYDEN. I think you're going to touch on a point that we're going to examine with the Health Care Financing Administration. Funds have gone down for these reviews. My concern is that at a time when it sure looks like both taxpayers' and seniors' interests are not being met now, I'm reluctant to hand over more dollars to these unaccountable private insurance contractors to do more reviews.

Now, if these additional dollars were given in line with some guidance by the Health Care Financing Administration, then I think the Congress could say this is additional money that could be well spent. But, if you start with a situation where they're not paying claims that they ought to pay and they're paying claims that ought to be denied—and the General Accounting Office has confirmed that for us this morning—and somebody now says, let's give some additional money to these private insurance contractors, it's kind of hard to justify doing that until we have some strong guidelines in place so that the contractors turn it around.

Now, some have said that the differences in these denial rates are due to local variations in medical practice, that there may be differences between something that's done in Oregon and something that's done in another part of the country. Has the Health Care Financing Administration done any studies with respect to the appropriateness of medical care in each carrier jurisdiction to determine whether medical practice variations account for these discrepancies?

Mr. SHARMA. Not that we know. But I think HCFA will be in a better position to answer this question.

Ms. HEDRICK. I think it would be unlikely that they could account for all of the variation that we have found in denial rates.

Chairman WYDEN. If you look at page 13 in your report—and I want to do this for a moment, because I think it illustrates part of the situation. Table 3 shows that the southern California Medicare carrier is finding between 17 and 25 percent of these cardiac imaging procedures as medically unnecessary. Northern California's carrier, on the other hand, has found only about 1/10 of 1 percent of these procedures to be medically unneeded. Is that correct a reading of that?

Mr. SHARMA. Yes.

Chairman WYDEN. Does the Health Care Financing Administration have any data to explain why southern California physicians might prefer to prescribe and conduct a great deal more medically unnecessary heart imaging procedures?

Mr. DOWDAL. Mr. Wyden, I would note in that table that the southern California carrier was the only carrier that had a screen for that service, and that would be the main reason—that should be the biggest reason explaining the difference among the carriers. If the other carriers had put in a screen, they would probably have denial rates too, instead of all showing zero.

Chairman WYDEN. Well, let's continue that for a second.

A possible explanation is that southern California's Medicare carrier is looking for medically unnecessary cardiac imaging and northern California's carrier is not. You would agree that that is a possible explanation, would you not?

Mr. DOWDAL. Yes, because of the absence of a screen.

Chairman WYDEN. While you're on the subject of Table 3, why don't you explain what a diagnostic screen and utilization screen are, if somebody doesn't speak this arcane kind of language of "carrier-speak" or whatever you might call it.

Mr. SHARMA. Utilization screens look for the frequency of service; that is to say that if a particular service—let's say, chest X-ray we will pay for it two times a year, and if a third time a bill appears, the computer screen will flag it and it will be denied because it can't be performed more frequently than has been approved.

The diagnostic screen, on the other hand, looks for specific diagnostic codes for which the procedure will be allowed. A particular procedure code may be allowed for four or five diagnostic codes, or it may be allowed for 10 or 15 codes; and that's essentially a function of the stringency of the criteria, and that's the primary difference between the utilization and the diagnostic criteria.

Chairman WYDEN. I think that Dr. Dowdal is saying that this may come down to the difference between somebody having a screen and somebody not having the screen. I gather that's something you think that is at issue here?

Mr. DOWDAL. That would be one of the main explanations, as we say in the report, for differences in denial rates across carriers. If you don't have a screen, you're not going to be denying very many claims, because without a screen, no one looks at a claim unless it happens to come up for some other reason.

Chairman WYDEN. Well, how do you explain, then, something like the difference between Illinois and Wisconsin? I mean, both of

them have screens—the situation for chest X-rays, a huge difference.

Mr. DOWDAL. Those kinds of cases are normally explained by the ones that we looked at in here because of the differences in the criteria used to screen. If one carrier has a criteria that says we'll allow five per year before we question it, and another one has a criteria that says we'll allow two per year, there is going to be a difference in the denial rates between those two carriers based on the criteria.

Chairman WYDEN. Which certainly raises the fairness issue, and I understand that. Has the Health Care Financing Administration, Dr. Hedrick, verified the scientific and medical validity of either the Federal California diagnostic screen or the absence of the screen in northern California?

Ms. HEDRICK. I think that would be a good question for them.

Chairman WYDEN. My understanding is that HCFA doesn't, because carriers develop their own screens. That's what you all have told us before.

Ms. HEDRICK. Right. They are at many times in consultation with local health care providers with an advisory body in doing that.

Chairman WYDEN. Now, even if HCFA doesn't write the diagnostic or utilization screens, has the Health Care Financing Administration officials been able to offer any data that would confirm the wisdom or appropriateness, to use this example, of the southern California carrier's diagnostic screen?

Mr. SHARMA. We have not asked.

Chairman WYDEN. Tell me what we know about the scientific basis of these diagnostic screens. Are the carriers required to reference their diagnostic screens in the medical literature?

Mr. SHARMA. We have only looked at this issue in reference to the California advisory committee, and so my remarks have sort of limited validity. But in California the carrier would—the medical director of that particular carrier would develop a policy, and the rationale for that policy may come either from their own experience or from literature. Then after they have the policy, they will send it to the members of the carrier's medical advisory board, who would be then given about 60 days to comment; and subsequently, the carrier would then incorporate those changes that come out from the physician medical advisory committee and incorporate it into the policy.

Now, the criteria for selection of the members is not based on whether or not they have a scientific reputation in that area, but that they represent the specialties, each of these specialties.

Chairman WYDEN. I guess what people really want to know—I guess what taxpayers and senior citizens want to know is how we can determine whether northern California's denial rate is too low or southern California's denial rate is too high. My sense is, we don't have any scientific basis for knowing that and both of them could be wrong; is that correct, Dr. Hedrick?

Ms. HEDRICK. We believe that you would need to develop additional information to be sure which one has the correct policy. But we believe that it's much more likely that people who should not be paid are being paid for services.

Chairman WYDEN. So the answer to that is you don't know now and we need to develop some additional information?

Ms. HEDRICK. Right.

Chairman WYDEN. Let me ask about one other example. On page 24, Table 6 of your report, for the southern California carrier, when we look at the first and third procedures, again in cardiac imaging, what does that table tell us about the percentage of providers who have had at least one medical necessity denial for these procedures?

Ms. HEDRICK. It indicates that there are, over 50 percent of the providers are affected by disagreements in place for those services.

Chairman WYDEN. How is this data consistent with the theory that local medical practice explains denial rates?

Ms. HEDRICK. It is beginning to look a little bit high. You would really have to look at the whole distribution to see whether you have a problem here.

Chairman WYDEN. Aren't the local medical necessity screens supposed to reflect local medical practice?

Ms. HEDRICK. Yes. This is the percentage, however, of providers that have at least one medical necessity denial, and we really would need to give you more information about how many of them had more than one to know whether they were really inconvenienced, and we can provide you with that information.

Chairman WYDEN. I think that would be helpful, but I think for purposes of my thinking, the only way you can really say that local physician advisory panels and these high denial rates really go hand-in-hand is to, in effect, say physician advisers signed off on the idea that there are too many medically unnecessary cardiac imaging procedures done in the area.

Ms. HEDRICK. That is correct.

Chairman WYDEN. Is that where we are left in terms of the current system?

Ms. HEDRICK. Yes.

Chairman WYDEN. Go through your recommendations, if you would, for how we are going to turn this situation around.

Ms. HEDRICK. We have three recommendations. We would like the Health Care Financing Administration to issue instructions to carriers on how to classify the reason for denial when reporting this information to avoid the confusion that has occurred between noncovered care and lack of medical necessity.

We would like them to analyze the usage of screens across carriers, including the stringency of the criteria used, and to make an effort to identify effective screens and to share that information across providers.

Finally, this issue you mentioned about the subpopulation of providers responsible for a large number of the denials, we believe warrants attention and that providers should profile the population—the carriers should profile the population of providers accounting for a large number of the denials.

Chairman WYDEN. So generally, the areas that I have used to really supplement your recommendations that we ought to zero in on the 5 to 6 percent that seem to be causing most of the problem, that is something that you are supportive of and you would also

be supportive of an effort to try to set up special guidelines where there are extremely large variations in carrier denial rates?

Ms. HEDRICK. Yes.

Chairman WYDEN. That ought to be done at the national level?

Ms. HEDRICK. Yes.

Chairman WYDEN. Review for me for a moment this matter of spending additional money where the carriers to review medical necessity claims. You all have found that a dollar spent in this area will produce something like $10 worth of savings?

Mr. DOWDAL. Yes. We have been looking at this issue for a number of years now and that is the general number. Our feeling is that there hasn't been—the number of claims have been increasing and the dollars to review those claims have not been and in fact, some kinds of safeguards areas have been decreasing. We don't believe there is enough emphasis on the safeguard activities of Medicare and that additional funding would be required to increase that emphasis.

Chairman WYDEN. I would be interested in your thoughts as to how a program could be set up in a responsible fashion, because if you are somebody hearing this for the first time, a huge variation from one part of the country to another, private insurance companies setting their own rules, 5 to 6 percent of the doctors causing most of the problem, lots of the claims being handled in the wrong fashion, people are going to roll their eyes if you say let's just shovel more money here at some unaccountable contractors. How could the Congress look at a way to ensure that dollars that were spent for additional contractor review actually paid off?

Ms. HEDRICK. I think that is a very tough question for us at this point. One of the dilemmas we face is that there are no incentives for the contractors basically to tighten the management, and having limited funds to screen service claims does limit what they can look at. Certainly there are some ways in which as we look at the variation across the different Medicare carriers, we can identify promising approaches to tighten accountability by looking at screens that certain carriers have found effective, by looking at whether problems were addressed and then reduced in certain geographic areas that were subject to those screens. But I don't think we are prepared to do that at this time.

Mr. DOWDAL. A specific answer to your question, we couldn't do that. We have always said there are problems with the way the carriers operate, they are not perfectly efficient by any stretch of the imagination, but it was obvious to us that there wasn't enough money there to adequately perform medical review of the claims and sufficient auditing of providers that are paid on a cost basis. There has been some more emphasis on the Medicare as a secondary payor program. That has been a little better funded in the last 3 years. Those are the three basic areas of safeguarding.

Chairman WYDEN. But generally you don't have objections to ensuring uniformity between carriers in these areas where there are huge variations?

Mr. DOWDAL. No. We believe it should be looked at so that if you look at a carrier that has a high denial rate, we believe that most of the time you are going to find that the other carriers with low denial rates are the ones that have the problem because they aren't

screened for that. If we have the other carriers screened for the same thing, they will also be denying the higher level of claims. Hopefully, over time through the education process and not paying doctors for services, they will stop doing services that aren't necessary and then the denial problem will go away.

Chairman WYDEN. In a number of States, is it correct to say that the insurance company that processes claims for Medicare also sells supplemental medigap insurance?

Mr. DOWDAL. Yes, that is almost always the case.

Chairman WYDEN. Do you think that that is a troublesome conflict, Mr. Dowdal?

Mr. DOWDAL. Since I don't see it as a big problem, it is possible that there could be some, but it shouldn't be a major problem.

Chairman WYDEN. I guess—again you are a taxpayer, and you say to yourself, there are two bins and there are two insurance companies—excuse me, there are two bins within one insurance company and they are running the program for the Federal Government and they get a fee for it but the insurance company really isn't at risk. Then there is another bin where they put their supplemental bills, their medigap supplemental bills. It just kind of seems like human nature that that insurance company, even though they say they are off at different ends of the building, that they throw that bill into the bin that goes to the taxpayer rather than the bin that goes to the private account where they have to pay claims privately.

Mr. DOWDAL. You really aren't asking about Medicare supplemental insurance, you are talking about health insurance that is primary to Medicare. In that case, there would be a substantial incentive for them to not pay under the commercial plan and have Medicare pay it when the commercial plan should be. In fact, I believe there have been a couple of indications where some carriers have been found doing that.

Chairman WYDEN. But if a carrier denies Medicare coverage, then it has no medigap liability; correct?

Mr. DOWDAL. Yes, but that is for a relatively small portion of the total.

Chairman WYDEN. How do you know that? We are not reviewing many claims. How do you know the answer to that?

Mr. DOWDAL. Is the question whether an insurance company——

Chairman WYDEN. You just said it doesn't happen in many kinds of instances. How do you know that? There is not a review of very many claims.

Mr. DOWDAL. I thought your question was asking whether insurers would have an incentive to deny Medicare claims because they also have a medigap policy for the same person, and I said I didn't think that would be a big problem.

Chairman WYDEN. I think what troubles us is medigap payments are the insurers' money and Medicare pays for its own claims; it doesn't get pushed off on the carrier.

It seems to me there is a conflict there, and I think what we will do is we will ask GAO to also look at this. But your opinion here is that is not troublesome to you, Mr. Dowdal?

Mr. DOWDAL. I have done a lot of work in the Federal medigap area and I don't see that as a problem. That doesn't mean that it isn't a problem. I don't see it as a big problem.

Chairman WYDEN. Why don't we also ask Dr. Hedrick for you all to look at the extent to which carriers screen criteria that represent local medical practice and also to determine the differential impact of Medicare denials on important subgroups of the Medicare population. I think we would find both of those helpful, as well as this matter of the relationship in States between the Medicare carrier being one company and the medigap supplemental being another.

It just looks to me like human nature that that one is going to go into the taxpayers' bin rather than the company's bin and we would like to have you inquire into it.

This is the second report that you have done and I hope that this will serve as a wake-up call for the Congress. I think that as you inquire deeper and deeper into this—also the fact that it seems that the repeaters, the people who have caused the problems, don't seem to change much from one year to another.

Dr. Sharma, maybe you want to confirm that. Did you find when you went back in the second year that it was the same people who were causing a big part of the problem?

Mr. SHARMA. We did not look at the individual physician level. We looked at the occasions and the numbers were the same.

If you do have denial rates persisting for more than one year, what HCFA and the carriers are doing when one does this kind of analysis, they use it as a tool to develop some strategies; thereby they can educate the physicians and look at—the issue here is that they are actually involved in some fraud and abuse or is it some inappropriate billing practice that is accounting for these denial rates but at the same time also identify providers that aren't doing as much as they should be doing and the issue here is—there are two issues here: One is to make sure that the dollars that we are spending are being spent appropriately and, second, that the care that Medicare beneficiaries are receiving is appropriate care. Because providing, paying too many bills for a service could also have some negative consequences.

Chairman WYDEN. I want to be sure on this point that when you found the problems the first year and you went back things didn't seem to be much changed; is that correct?

Mr. SHARMA. That is correct.

Chairman WYDEN. You all have been very helpful.

As the fairy tale goes, this story gets curiouser and curiouser, and we will continue to utilize the good offices of the General Accounting Office. Thank you for excellent work on this job and we will excuse you at this time.

Ms. HEDRICK. Thank you.

Chairman WYDEN. Let us have Dr. Vladeck, Administrator of the Health Care Financing Administration, come forward now.

Dr. Vladeck, it is the practice of the subcommittee to swear all the witnesses who come before the subcommittee. Do you have any objection to being sworn?

Mr. VLADECK. No.

[Witness sworn.]

Chairman WYDEN. We are going to make your prepared remarks a part of the hearing record in their entirety, Dr. Vladeck, and why don't you just proceed in any way that you feel comfortable.

TESTIMONY OF BRUCE VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman. Let me provide a brief summary of my written testimony and then, of course, I will be happy to respond to any questions you might have.

I am pleased to have the opportunity to discuss Medicare's procedures to process, monitor, and pay for beneficiary services. We are committed to running an equitable program that pays for medically necessary services for beneficiaries in a fashion that is as consistent as possible. We always realize that there are improvements that can and should be made and we are taking steps to improve consistency within the Medicare claims processing system, while recognizing that, in a nationwide program in a Nation such as this, sources of local variation will remain.

As you know, in 1994 Medicare served over 36 million beneficiaries for Part B Medicare contracts with 34 carriers and other entities to process claims. In fiscal year 1993, those carriers processed almost 580 million claims, resulting in $52 billion in payments to physicians and other Part B suppliers.

Carriers are responsible for determining which claims to pay and how much to pay. Each carrier conducts prepayment and post payment review of a sample of claims to help ensure that only appropriate claims are being paid. That sampling is based on systematic analysis of utilization data to detect areas that require special attention.

In conducting our activities, contractors follow national policies expressed in statute, regulations, and manual issuances. While governed by these directives, carriers are also expected to exercise discretion in areas not specifically addressed through a national policy. Thus, carriers are bound by national coverage decisions that we issue where such decisions exist.

These decisions, in turn, largely arise from a situation in which there is a clear national consensus on treatment, but that does not characterize all medical practice, particularly in an era when technological change is very rapid. In fact, formal national coverage policies encompass only a relatively small part of the coverage decision carriers must make every day.

In circumstances where a reasonable degree of national consensus has not emerged, we strongly encourage carriers to work with each other and with us to establish consistent standards while ensuring that carriers have flexibility to allow for reasonable local variation.

HCFA requires that local policies be developed in consultation with the local medical community through the State carrier advisory committee to ensure that local medical practices are taken into account.

Carriers are also expected to be energetic in implementing local medical review policies that will best protect the integrity of the Medicare program. Our focused medical review initiative allows carriers to focus on problems specific to their areas. Focused medi-

cal review provides carriers the flexibility to target their efforts on particular items or services unique to their region that they identify as potentially overutilized or otherwise problematic.

One result is that while claim denial rates for particular services may vary from area to area, this may simply reflect billing patterns and not necessarily be indicative of the differences in the level of services we ultimately pay for.

Let me give you some examples. For cataract extractions, our southern California carrier denied almost 11 claims per 1,000 submitted while in Illinois the denial rate was 1 per 1,000. However, those numbers do not mean that beneficiaries are receiving significantly different levels of medical service. For cataract extractions, allowed services per 1,000 enrollees were 24.9 in southern California and 24.6 in Illinois.

Another example relates to the use of chemotherapy for prostate cancer. The North Carolina carrier had a denial rate of 17.1 claims per thousand services while the Wisconsin carrier denied 2.7 claims per thousand. The allowed service rate per thousand enrollees, however, were very close, 5.9 for North Carolina and 5.1 for Wisconsin. Despite the large differences in denial rates across carriers, utilization of services was very similar.

Possible reason for differences in denial rates include local variations in medical practices, varying billing patterns that may indicate problems with payment integrity, or simply with provider and provider staff education and local medical review policies. While these factors contribute to the wide variations in denial rates, the underlying similarity in the allowed service rates is what we would expect to see if the system is working correctly and is paying appropriately for the necessary and reasonably services required by our populations.

In short, while Medicare is a national program, we must recognize that medical practitioners frequently differ in their opinions of accepted norms of medical practice across the country. In circumstances where a reasonable degree of national consensus has not emerged, we should not impose standards of medical practice from Washington. Rather, we should assure that sound medical policy is established and that carriers can make clear decisions on which claims to pay based on those criteria.

The GAO was kind enough to share a draft of the report they presented today, and I would like to comment briefly on some of their findings.

Each carrier has its own unique screens in place to suspend those claims that reflect identified problems in local medical practices and the behavior of suppliers that serve each geographical area. This means that intentionally all carriers are not screening for the same codes. For example, to take one of the examples you discussed, there is a large variation in denial rates for echocardiography. Three of the carriers—northern California, Wisconsin, and Minnesota—screened specific providers that had been identified as billing aberrantly. In comparison, the southern California carriers screened all claims related to this service regardless of the provider.

Obviously, when more claims are reviewed the result is often a higher incidence of denials, as the results for southern California

suggest. When you look at the "allows services data" for allowed echocardiography, however, the rates of allowed services were similar across the six carriers surveyed about, with rates ranging from 38 or 46 per thousand enrollees. Therefore, rates of claims approved for this procedure were similar despite the variation in claim denial rates.

Differences among carriers who claim denial rates can also be caused by differences in how they screen for medical necessity. On average, almost 17 percent of denials result from inadequate justification of medical necessity, but carriers differ on how they monitor such claims. For example, one of the codes you also discussed in the General Accounting Office study was for chest X-rays. Illinois had a medical necessity screen in place to see if the diagnosis was appropriate for the service because of the issues that were specific to Illinois and they had a denial rate of 80 claims per thousand services. Two other carriers did not have any screens in place at all. The average denial rate for those carriers was 3 claims per thousand services. However, again, the allowed services rate was similar among these three carriers.

Although a certain degree of variation in the review and processing of claims is expected, we are promoting greater consistency in local policy where that is appropriate and consistent with the facts. There are differences in the medical community from place to place, but there are clearly places where differences should be scrutinized and pursued more aggressively in order to assure that beneficiaries are receiving the services and equipment that we do cover and that are medically necessary.

We have taken several steps to ensure that carriers work with the local medical community through the use of the mandated carrier advisory committees in each State which develop local medical review policy. We believe that efforts to promote better communication and cooperation among carriers and among the advisory committees will result in more consistent national policy across carriers.

We have instituted a policy in which the medical directors of carriers meet on a regular basis to share information. They are now sharing their local medical policies and screens with one another and groups of carrier medical directors have also formed small work groups to develop model policies to help guide the carriers in formulating new medical policies and guidelines.

We are developing a centralized file of local carrier medical policies that can be easily accessed by all carriers. Now each carrier can look at the other's medical policies and use them to improve their own policies and to address problematic issues regarding local medical practices in their communities.

Perhaps more importantly, we are currently implementing and developing initiatives to improve the claims processing system more generally. Starting in October 6 last year, we have gradually transferred the processing and monitoring of durable medical equipment and supplies from 34 Part B carriers to four durable medical regional carriers. Through these four carriers, we hope to achieve greater efficiency in claims processing and greater consistency in development and application of coverage policy and medical review. We are working with the four carriers to develop coverage

policies that are essentially nationally consistent. The goal, of course, is to pay appropriately for those items that are reasonable and medically necessary for medical treatment in a fashion that is comparable across the country. By reducing the number of carriers, we have reduced the degree of variation in policies across carriers.

The most important of our initiatives is the development of the Medicare transaction system. The MTS will allow the processing of claims with one standard processing system at a small number of sites instead of the 60 sites we are currently using. Because it will involve the integration and consolidation of all Medicare claims, processing MTS will greatly enhance HCFA's capability for electronic analysis of claims.

The MTS will allow us to capture national data and make it readily accessible. It will also provide greater capacity to understand individual provider service patterns and the types of services being provided as well as give us greater potential to identify fraud and abuse in the course of processing claims. Therefore, MTS will help us improve services to beneficiaries and providers alike, increase our administrative efficiency, and help in the management of Medicare program expenditures. We expect to begin phasing in MTS over a 2-year period starting in 1997.

In conclusion, let me say that the issue of variation and denial rates is complicated and hard to address with one solution. As I have stated earlier, variation in denial rates are due to many factors. By recognizing and identifying the causes of variation, we can focus on ways to make local medical policy more consistent and to work with carriers in identifying ways to reduce aberrances and identify potential fraud and abuse.

We believe that looking at variability in denial rates by itself does not provide a picture of the services provided to beneficiaries nor does it necessarily mean that Medicare beneficiaries and providers from one region to another are treated inequitably. When variation does point to a problem of consistency, we take steps to address the issue as soon as possible.

Through the efforts just described, we are moving forward to use new technology to better serve our beneficiaries. While we work to improve our current claims processing system, we are committed to assuring equitable access to covered medical services, treatment, and equipment for all beneficiaries.

Thank you very much for the opportunity to appear today, and I am happy to respond to any questions you might have.

Chairman WYDEN. Mr. Vladeck, thank you.

[Mr. Vladeck's statement may be found in the appendix.]

Chairman WYDEN. Let me ask you first, are you all troubled by these very large variations in denial rates?

Mr. VLADECK. I was substantially more troubled, Mr. Chairman, until we looked at what the actual service rates or rates of approved procedures associated with those differences were. Once we found how little variation there was in the approved services rates, then I actually began to feel that the variation in denial rates suggested the carriers were doing a better job than perhaps I had expected.

Chairman WYDEN. I find that puzzling because I note that in U.S. News and World Report, for example, earlier, the Health Care

Financing Administration indicated that they were taken aback by the General Accounting Office's findings. The General Accounting Office told me when I asked, they said that the system really is not one in which Medicare can make sure that it is fairly dealing with claims that ought to be denied and fairly dealing with claims that ought to be paid. They basically said that this is a program that does not have the ability to distinguish those differences, and you are not troubled by any of this?

Mr. VLADECK. I am very troubled by that General Accounting Office statement and I am not sure the evidence on which it is based. We were taken aback by the General Accounting Office study of 2 years ago and it did cause us to look in much more detail at denial rates and again at underlying approval rates, and what it found was that while there is very considerable variation in denial rates from carrier to carrier, underneath the denial rates there is a strikingly high degree of consistency in approval rates from carrier to carrier. That suggests to me that the system of focused medical review in which we require the carriers to develop automated screens based on analysis of patterns unique to their service areas is working better than I think one might have expected it would.

Chairman WYDEN. The thing that occurs to me, and why the system really can't distinguish between kinds of claims that ought to be paid and the kind of claims that ought to be denied is that the General Accounting Office tells us that too few claims are being reviewed, that that is right at the heart of the problem.

Do you disagree with the General Accounting Office on that point, too?

Mr. VLADECK. We believe it would be better to review more claims. However, I don't believe the GAO has a basis to say any quantitative estimate of how many claims we are inappropriately denying or how many claims we are inappropriately approving and I don't see that in their study.

Chairman WYDEN. Does the Health Care Financing Administration permit the carriers to decide simply not to check the medical necessity of claims for a given medical service?

Mr. VLADECK. Yes, we do.

Chairman WYDEN. Is it true that different carriers might decide to scrutinize different services for medical necessity so that in one carrier all claims are approved and in another 10 percent or more might be denied as medically unnecessary?

Mr. VLADECK. In the first instance, none of the claims would be denied for medical necessity. They might be denied for other reasons. But it is true that some carriers will deny only very few claims for medical necessity whereas others will deny a much higher proportion.

Chairman WYDEN. Let me ask you the same questions that I asked the General Accounting Office, to go through the example because some have said that the differences in denial rates are due to variations in local medical practice. Has the agency done any studies of the appropriateness of medical care in various carrier jurisdictions to determine whether medical practice variations account for the discrepancies?

Mr. VLADECK. We have done some, but what we have found is that we have the highest rates of variation in procedures, in those

procedures which have been identified in the literature as having a high degree of unexplained variation; for example, certain elective surgical procedures.

Chairman WYDEN. Let's ask about this denial issue in another way. Few denials hypothetically mean little variation in approval rates. Is that good?

Mr. VLADECK. No, I don't know that that follows.

Chairman WYDEN. Well, it sure looks like that is the point that you all are making. You have tried to minimize the denial rate situation, which strikes me as being a very serious fairness issue for seniors across the country with Medicare looking like it is more relevant, the program is based more on where you live rather than on what you need, and——

Mr. VLADECK. I don't understand your point.

Chairman WYDEN. The only explanation I can kind of get for your justification that there aren't that many denials, that it is based on the proposition that few denials mean little variation in approval rate.

Mr. VLADECK. No, I didn't say that there were few denials. I said that in those areas in which there are high denial rates we are still approving as many claims as in those areas in which there are low denial rates. We are just receiving a lot more claims in the areas with the high denial rates. That is why we are focusing on those procedures. That is why we have automated edits in those areas for those procedures and that is why we are denying more claims in those areas. If we receive twice as many claims in region A as region B for a particular procedure, we look more closely at the claims in region A.

Chairman WYDEN. I guess that is kind of hard to believe when Dr. Sharma told us that there wasn't any change from one year to another, even when a region had problems. I guess I see so much of what you are saying being contradicted by the testimony this morning of the GAO and the reports. Dr. Sharma told us that he went back the second year to see if there are changes from the first year as it related to a small number of providers causing most of the problem. You said you monitor it carefully and go back in if you see there is a problem.

Mr. VLADECK. I don't believe Dr. Sharma said they are always the same providers.

Chairman WYDEN. He said the overall problem remained the same. You said, because I asked, that what you do is try to monitor various areas with a problem and go back in to try to take corrective action and Dr. Sharma said that he went back the second year and didn't see any difference between the problems that cropped up the first year.

Mr. VLADECK. I don't believe he was asked to respond on the level of specificity of individual providers, but he will have to respond to that question.

We have not over the 2 years intervening between the two General Accounting Office studies effected major changes in patterns of medical practices in any of the areas at which the GAO looked; I think that that is true.

Chairman WYDEN. Let me ask you about the example I asked General Accounting Office as well. You have the report here?

Mr. VLADECK. Yes.

Chairman WYDEN. This is the matter of the southern California Medicare carrier finding that between 17 and 25 percent of the first two cardiac imaging procedures were medically unnecessary. The northern California carrier, on the other hand, found only about 1/10 of 1 percent of these procedures to be medically needed. I don't think we have to go through all of the questions of whether this is correct. What do you think explains this?

Mr. VLADECK. I think what explained it is that there are—there were a couple of physicians in southern California who were doing two things. One, who were billing a lot of echocardiography services that we believed were unnecessary, and, second, who kept resubmitting denied claims to us, and the way the data was compiled in the General Accounting Office study, those were all counted as multiple denials. That is one of the reasons that southern California put in a special screen to look at echocardiography.

I should also tell you that the rate of approved echocardiographies in southern California was only slightly higher than it was in northern California.

Chairman WYDEN. I think this is, again, the continuation of the debate we have had, that the approval rate, in your view, stays unchanged and that is why nobody should be particularly alarmed.

I guess—what is the scientific basis of this system, which I think to most people looks pretty bizarre—the General Accounting Office said that they were not sure whether you all were required—whether you all required of the carriers that they have some sort of scientific basis for the diagnostic screening. Do you require that?

Mr. VLADECK. Yes, we do. We require each carrier to maintain a system of post payment patterns analysis and utilization analysis from which they identify problems for focused medical review, which are the basis for their identification of what screens they apply to the screening of subsequent claims.

Chairman WYDEN. Where does the science come in?

Mr. VLADECK. The science is the science of statistical analysis and statistical sampling which drives the entire claims review process.

Chairman WYDEN. I would be real interested in seeing any scientific analysis, because the carriers that we have talked to don't seem to be under the impression that this kind of scientific analysis is required of them, and certainly this system really seems to me to be one where contractors largely get to free-lance and make their own judgments as to how they are going to pay these claims and how not to deal with them, and then you all come along after the fact in this kind of post payment arrangement and look at what your testimony describes as the sample and then say all is well and don't anybody get rattled.

What do you think of the proposals that I make in my testimony that there at least ought to be some national guidelines in areas where there are large variations?

Mr. VLADECK. There has been considerable discussion, as you know, Mr. Chairman, in the context of health care reform and other discussions as to whether guidelines adopted through a position of an agency, such as the Agency for Health Care Policy and Research, should be primarily educational or whether they should

be given the force of law and whether Washington should legally be describing patterns of physician practice. We always review guidelines as they are issued by AHCPR. In many instances, we have adopted them.

On the other hand, we think to turn over that level of control of medical practice in every community in the United States to individual advisory groups working for the Federal Government is inconsistent with continually improving the quality of medical care and inconsistent with the capacity of those guidelines to be continually updated to reflect changing medical technology.

Chairman WYDEN. So even if there is a very large variation, we are just going to stay the course?

Mr. VLADECK. If there is a very large variation and there is a very strong degree of medical consensus about appropriate patterns of care, we will adopt national guidelines based on that consensus.

Chairman WYDEN. Give me an example of where you have done that. The General Accounting Office has been doing these reports for a couple of years and made recommendations. As far as I can tell, you are saying that the General Accounting Office finding is no big deal. The General Accounting Office told me in testimony under oath that they don't think there is a system to make sure that appropriate denials and appropriate payments go forward and you are saying no big deal.

Mr. VLADECK. No, sir, I think you are confusing the basic issues. One is what is medical coverage policy, that is to say, when do we pay for bypass surgery, when should we not pay for it. Or when will we pay for a certain anticancer drug and when will we not pay for that. We have moved to clarify national coverage policies whenever the consensus of the medical profession permits the establishment of national policy. Once you have a national coverage policy however, you are going to have variations in practice from one part of the country to another and you are going to have variations within communities depending on the practice styles and predilections of individual physicians. In order to assure uniform application of a uniform national policy, you are going to have to focus your claims review activities on different problems and different providers in different communities, and in order to administer a national policy uniformly you are going to get variations in denial rates because it is not a uniform world out there in which you are trying to administer a uniform policy.

Chairman WYDEN. I guess to get to that point requires that you see some specific policy. My view is that you just hand this over to insurance carriers and they can do their own thing.

Can you give me an example of one where when there was a large variation pointed out you got together with the medical communities and put in place a responsible national guideline in response?

Mr. VLADECK. I would say the most dramatic example was probably in '84 when we announced that with a limited amount of advance notice that we would no longer pay for inpatient cataract surgery, except under very narrow medical exceptions.

We have adopted a number of very specific policies about when we will pay for interocular lenses in conjunction with cataract surgery and when we won't. We have a lot of national coverage poli-

cies relative to a lot of arterial surgery and other forms of peripheral organ surgery that in the past we felt was subject to abuse with important clinical as well as economic consequences.

It is often much easier to make clear-cut national rules relative to indications for particular surgical procedures than it is for patterns of treatment for particular medical illnesses because there tends to be more professional consensus around indications. But we left literally dozens of national policy. The carrier manual is full of them. On the other hand, there are 10,000 separate procedure codes under which physicians can bill under the Medicare program and we don't have a national policy for every permutation of combinations of those codes on a bill.

Chairman WYDEN. Let me ask you if you followed up on any of these huge differences in claim denial rates that the General Accounting Office found in 1992. You have had a year for that kind of report. They produced new findings that we have made available today, but they found in 1992, for example, that an older woman whose doctor prescribes a diagnostic mammography to detect breast cancer is 180 times more likely to have Medicare deny payment for that mammography if she lives in southern California than if she lives in northern California. Did you look into that?

Mr. VLADECK. Yes, we have and we have looked particularly at the issue of mammography. The Medicare beneficiary in northern California is almost exactly as likely to receive a diagnostic mammography as the Medicare beneficiary in southern California. We have worked with the carriers in the high denial rates to try to figure out what was behind the high denial rates and to eliminate the problem causing the submission of lots of unapprovable claims.

Chairman WYDEN. So there is no problem any more with respect to mammography between northern California and southern California? If there is a differentiation in denial rates, it will be pretty small?

Mr. VLADECK. I don't know that we have achieved that change in behavior yet.

Chairman WYDEN. How about this one in the ambulance area? The General Accounting Office found that a one-way ambulance ride in Illinois is almost always paid for. The claim for the same trip in southern California is 740 times more likely to be denied.

Mr. VLADECK. We have a lot more abusive ambulance claims in southern California. That was the subject of a hearing in the other body just last week, and we have implemented a number of new medical review procedures to look specifically at ambulances within the last year.

Chairman WYDEN. So that is going to be changed?

Mr. VLADECK. Yes. I can't tell you it is going to be solved. Ambulance claims are particularly hard to evaluate for medical necessity, but it is certainly being dressed.

Chairman WYDEN. How about the chest X-ray finding that the General Accounting Office found the Medicare contractor in Illinois 500 times more likely to deny payment for a chest X-ray than the South Carolina carrier?

Mr. VLADECK. That is correct, and again there were a few physicians in Illinois who were billing a lot of medically unnecessary chest X-rays. The carrier has addressed the problems of those phy-

sicians. I can't tell you what the resolution of that is, however. Even if we were to pursue the remedies that are available against providers who bill unnecessarily, given the due process requirements involved, we wouldn't have completed such actions in this period of time anyway.

Chairman WYDEN. At least it seems that you have gone after some of the ones that the General Accounting Office found in 1992, but I hope that you all will look at the seriousness of what the General Accounting Office has found, because the General Accounting Office is questioning the fundamental management underpinnings of this program, and at a time when Members of Congress on both sides of the aisle are looking at Medicare. This is such a big program, Medicare overall has been a wonderful program for senior citizens. When the General Accounting Office comes in and says point language that they agreed with my statement, this Medicare doesn't pay claims that ought to be paid and Medicare pays claims that ought to be denied, I hope you and your people will take that to heart, because this is a $60 billion program that is going to be on the front lines in terms of congressional scrutiny. People will say, let's whack here and let's whack there, and I hope that you all will move to implement the suggestions of the General Accounting Office for better supervision of the program, and I hope you will look seriously at what I am talking about.

By the way, as I said in my opening statement, where there would be national guidelines for services and procedures with large variations in denial rates, I think it is fine to try to factor in these local considerations by giving carriers the option for a waiver if they have a chance to show that they can come up with a creative program that can address the needs of seniors, taxpayers, and providers. But I hope we won't just say no big deal here, the denial rate isn't very high in many respects, just because there haven't been very many claims reviewed, because not reviewing many claims at a time when we are seeing the kinds of variations that the General Accounting Office has found I think is a serious matter.

Mr. VLADECK. Mr. Chairman, again, I believe it is important to distinguish between variation in denial rates and variation in approval rates. In fact, our data suggests that we have remarkably consistent national application of coverage policies. We don't have a homogeneous Nation in which providers bill us at the same rates for all procedures the same all across the country. To the extent that we continue to experience aberrant patterns of billing or unusually high volumes of utilization in one part of the country as opposed to another, we will go after those bills much more aggressively than we go after the average bill. I think that is entirely consistent with prudent and effective administration of the program.

Chairman WYDEN. One other point on this, because we clearly have a disagreement on the importance of denial rates. I side with the General Accounting Office, and you all seem to say this is not much of a matter. Is it a mathematical probability that approval rates will be similar if there are few denials?

Mr. VLADECK. No. It depends—you can't answer that question unless you know what the claims rates are.

Chairman WYDEN. All right. I find it hard to see how you are really going to get on top of the claims issue unless you go out and review some claims, and the evidence from the General Accounting Office is you don't review most of the claims even for the most expensive services.

Mr. VLADECK. We review as many claims as budgets permit. We review 30 or 40 million claims a year on the basis of the automated, on the focused medical review, as well as other claims we review for other purposes.

Chairman WYDEN. We are also interested in this budget matter. Do you share the view of the General Accounting Office that if a dollar is spent on claims review something like $10 can be saved on claims review down the road?

Mr. VLADECK. That has been our experience in recent years, yes, sir.

Chairman WYDEN. What would you recommend to the Congress for purposes of the next session in this area? Are you calling for additional funds for claims review?

Mr. VLADECK. It is not generally the practice of executive agencies to make budget recommendations to the Congress in advance of the President's budget.

Chairman WYDEN. What is your opinion?

Mr. VLADECK. I think the evidence is very clear that the rate of return on all of our program integrity activities, all our payment safeguard activities is very large and very positive.

Chairman WYDEN. I have to tell you, I sit on the Health Committee and I am very sympathetic to the idea that there should be an effort to try to get more resources to those carriers, but I will be darned if I am going to see taxpayers shovel out more dollars to unaccountable private insurance carriers in your program.

We have a situation now where the General Accounting Office has said that there is not sufficient guidance for these private insurance contractors. The insurance company in their own study, the one I cited in my opening statement, Transamerica, agrees that there isn't sufficient guidance and you all say everything is fine. I hope between now and the time that Congress gets to these budgetary matters that you all will take another look at this, because I know that you mean well and you wish to do the right thing. I have agreed with the vast majority of things that you have taken on at the Health Care Financing Administration, but I think that the agency needs to take another look at this and follow up at least on the recommendations of the General Accounting Office.

Is there anything you would like to add further?

Mr. VLADECK. No, sir.

Chairman WYDEN. We will excuse you at this time. We thank you for your cooperation.

Chairman WYDEN. Miss Diane Archer, Executive Director of the Medicare Beneficiaries Defense Fund.

Ms. ARCHER. Thank you.

Chairman WYDEN. We do have to take care of some formalities. Do you have objection to being sworn as a witness?

Ms. ARCHER. None at all.

[Witness sworn.]

Chairman WYDEN. We will make your prepared statement a part of the record, and I have enjoyed working with your organization for many years. Please proceed in the fashion you feel comfortable with.

TESTIMONY OF DIANE ARCHER, EXECUTIVE DIRECTOR, MEDICARE BENEFICIARIES DEFENSE FUND

Ms. ARCHER. Thank you. We appreciate the opportunity to address the Committee on Small Business's Subcommittee on Regulation, Business Opportunities and Technology.

My name is Diane Archer. I am executive director of the Medicare Beneficiaries Defense Fund. We are a not-for-profit organization that works to assure equal access to quality health care for seniors and people with disabilities on Medicare. MBDF provides seniors and people with disabilities on Medicare with direct assistance through a nationwide telephone hotline program. This year alone, we received more than 15,000 calls concerning Medicare and related health insurance problems on our telephone hotline.

Through our direct services to Medicare patients, we identify systemic failings and limitations in the Medicare program, recommends changes to correct them, educates the public about Medicare issues, empowers seniors and people with disabilities to help themselves and, where necessary, take corrective action on their behalf.

At the outset, we want to emphasize that the Medicare program currently works extremely well for the vast majority of Medicare patients who are in relatively good health. Our clients, however, tend to be the Medicare patients in poor health, with limited resources. Perhaps the largest single problem these Medicare patients face is securing access to necessary health care services and appropriate coverage for these services. Medicare routinely but erroneously denies and reduces benefits for physician services, hospital care, skilled nursing facility care, and home health care. According to recent HCFA statistics, more than three-quarters of all claimants who appeal initial Medicare coverage denials receive coverage. Unfortunately, however, only 2 percent of the seniors and people with disabilities denied coverage have the information or resources necessary to appeal and correct erroneous Medicare claims denials.

We believe that Congress should view this reversal data as evidence that the Medicare system wrongly denies coverage on a routine basis and that HCFA has not acted to correct systemic problems in claims administration. The resulting Medicare system all too often imposes a horrifying dilemma on countless seniors and people with disabilities on fixed incomes: They can either forego necessary medical care or risk impoverishment by agreeing to pay privately for the services that Medicare wrongly refuses to cover.

We believe that a significant factor in the unacceptably high rate of erroneous claims denials is the fact that HCFA permits the 60 Medicare carriers and intermediaries process claims on the Part A side and the 141 Medicare HMO's to develop different sets of medical policies and standards for determining whether Medicare will provide coverage for a particular medical service.

HCFA could impose uniform and detailed coverage standards on each of its regional carriers, fiscal intermediaries, and Medicare HMO's. The application of these uniform standards throughout the Medicare system would be subject to oversight, review and correction by a single Federal agency with the responsibility for implementing the Federal Medicare statute. Instead, within a broad framework established by the Medicare statute, HCFA regulations and national coverage decisions, the individual Medicare carriers which administer Part B claims and the fiscal intermediaries which administer Part A claims are generally free to establish their own coverage and claims denial criteria—deciding whether services are experimental and establishing norms through utilization and diagnostic screens to make an initial determination whether services are excessive or inappropriate given a particular diagnosis. Moreover, the Medicare system allows each of the 141 Medicare HMO's to develop their own coverage standards within the broad framework established by HCFA regulations and national coverage determinations.

The resulting quiltwork of conflicting Medicare policies means that Medicare will cover certain medical services in some regions and deny coverage for the same services in others. Even more distressing, with the emergence of Medicare HMO's, the same medical service performed by the same provider in the same community may or may not be denied Medicare coverage depending upon whether the patient is enrolled in a Medicare HMO and which Medicare HMO the patient chooses. This trend is certain to increase in the future as the health care industry shifts to a managed care system and more and more seniors and people with disabilities are enrolled in Medicare HMO's.

The General Accounting report released today amply documents the substantial variation in denial rates among carriers for medical necessity. Although the General Accounting Office report does not discuss whether this patchwork system of Medicare coverage affects health care delivery, our experience suggests that carrier discretion to develop their own medical policies in fact, undermines equitable access to quality health care for seniors and people with disabilities. In particular, we believe that HCFA's failure to establish uniform coverage policies for all 34 regional carriers has contributed to three fundamental problems with the Medicare system.

First, the ability of carriers to develop independent medical policy to understand what services are covered. Without the variations in medical policy, Medicare is extraordinarily difficult for most people to understand. With the variations, even we at MBDF—who focus exclusively on Medicare issues—are hard pressed to stay on top of the difficult, constantly changing coverage policies throughout the country.

Ms. ARCHER. This system simply does not permit Medicare patients in ill health any reasonable opportunity to understand their health care rights.

Second, MBDF's experience in assisting hundreds of seniors and people with disabilities suggests that carrier medical policies tend to discourage physicians from delivering necessary care. We know from both utilization studies and our own caseload that Medicare home health care practice patterns vary widely in the 50 States.

Here you might want to take a look at the chart we appended as Appendix A showing utilization rates in the home care area.

In Tennessee, 117 out of every thousand Medicare patients received an average of 100 covered home care visits in 1992. In New York, however, 57 of every thousand Medicare patients received an average of 38 visits in 1992.

This extreme variation in home health care usage is, we believe, a direct result of the independent and conflicting medical policies that are designed and enforced by different fiscal intermediaries for Tennessee and New York respectively. Home health agencies are not paid to bear the financial and administrative costs of challenging initial coverage denials by fiscal intermediaries. They are just not inclined to provide home health care services where they know they will receive a first-level coverage denial from a fiscal intermediary, even when they stand a good chance of overturning that initial denial on appeal.

Uniform national standards would at least assure equitable delivery of covered home health services throughout the country. Our experience with Part B Medicare claims suggests a similar problem. Like home health agencies, doctors are not generally inclined to assume the financial and administrative burden of fighting carrier utilization screens on medical policies on a case-by-case basis. As a result, many doctors require Medicare patients to sign waivers agreeing to pay privately for medical services if Medicare denies coverage. I've attached examples of such waivers in appendix B.

This growing practice of requiring patients to sign these waivers forces seniors and people with disabilities to choose between necessary medical care and risk of financial ruin. That, we submit, is not how this country's Medicare system should work. Again, this problem would be reduced significantly if HCFA established uniform medical policies for all carriers and carefully oversaw, reviewed and corrected individual carrier policies to assure consistency in health care delivery.

Third, the wide discretion afforded individual carriers actually prevents HCFA from establishing appropriate Medicare coverage policies for some medical services.

In the absence of uniform national standards, for example, HCFA advised us that it lacks any administrative mechanism to require Blue Cross of Western New York to cover a particular combination of medical services. In this case, it was a Swan-Ganz catheterization and an A-line insertion, even though every other carrier in the country appeared to provide Medicare coverage for this combination. As a result, MBDF clients that received these services in upstate New York had to appeal their denials in downstate New York before a different carrier that covered this particular combination of medical services. Many people who do not know their rights and who did not know to transfer their cases downstate to MBDF simply went without coverage.

Finally, HCFA's failure to establish uniform national coverage policies has greatly magnified each of these problems for the more than 2 million Medicare patients now enrolled in HMO's.

In contrast to Medicare's carriers and fiscal intermediaries, Medicare HMO's typically maintain no standard policy for denying claims. Many of our clients do not understand that they are enti-

tled to appeal a Medicare HMO decision to deny them services. The HMO may never issue a written denial, and even when HMO patients appeal and win Medicare coverage they do not always receive the medical care they need.

Our client, Mrs. K, was enrolled in a Medicare HMO but could not secure necessary chiropractic care because her HMO refused to cover the service. The MBDF appealed the denial of care, and an administrative law judge ordered Mrs. K's HMO to provide her chiropractic service. The HMO still refused to provide her chiropractic services; and Mrs. K, tired of fighting, had no choice but to disenroll from the HMO in order to secure the care she needed.

The adoption of uniform national coverage polices would allow MBDF and other senior advocates to resolve the growing number of HMO problems such as Mrs. K's on a systemic basis rather than HMO by HMO. In short, if equitable access to quality health care is to be anything more than an empty promise, then HCFA must standardize coverage criteria in both the HMO and fee-for-service settings.

There is no compelling reason why medical policy should be substantially different in different parts of the country and in different HMO's. Instead, carriers, fiscal intermediaries and HMO's should only be able to establish their own medical policies in exceptional circumstances for a temporary period where they are testing new coverage guidelines or they detect patterns of abuse that HCFA has not yet addressed through national policy. In those circumstances, HCFA must ensure that Medicare carriers use these medical policies rationally and effectively while HCFA develops appropriate national coverage standards.

I included specific recommendations with my written testimony which I ask to be included in the record. Thank you. I'd be happy to answer your questions.

Chairman WYDEN. Thank you for an excellent job.

[Ms. Archer's statement may be found in the appendix.]

Chairman WYDEN. I want to make sure that it's clear exactly what one of these additional concerns you're raising is all about.

The General Accounting Office has raised questions about very serious inequities in the variation in denial rates among what amounts to the traditional Medicare insurance companies, the 32 private carriers. What you're saying is that there could be potentially much more serious problems with variations because there are 140 Medicare health maintenance organizations and presumably a lot less is known about those organizations than each the 32 private insurance companies; is that correct?

Ms. ARCHER. Absolutely correct. I would go one step further. I would say that there are more serious variations in the HMO's because I believe that they are monitored even less than the carriers and the fiscal intermediaries at this time.

Chairman WYDEN. It would be hard to see how you would monitor anybody less than the Health Care Financing Administration was monitoring these private carriers.

But you're on the frontlines, and I want you to know that I'm going to follow this up with the General Accounting Office as well because there are many more Medicare HMO's than there are private carriers. We found serious inequities among the private car-

riers, and you're now coming and saying that you're finding even more serious problem with the HMO's, and this ought to send a message to policymakers for discussion.

Ms. ARCHER. That would be wonderful, if you would. Because, even with regard to the issuance of denials, HMO's don't seem to have a national guideline to follow. So, one HMO may say come back in a year and not issue a denial. Another HMO may issue a denial if they're not going to see you for 6 months. Each one has a different standard for advising a Medicare patient about delivery of care.

Chairman WYDEN. Are you finding more problems coming into your program now from HMO's as it relates to confusion on this matter?

Ms. ARCHER. We are finding a rising number of calls coming in in the HMO area. There are now slightly more than 2 million Medicare beneficiaries enrolled in HMO's. I believe there are a growing number of Medicare HMO's in the country, and I assume that many more Medicare beneficiaries will be enrolled in HMO's in the coming years.

Chairman WYDEN. Do you think that the confusion about these denial rates is going to harm access to care for your clients?

Referring to one of the articles in the press, one of the physicians very active in the California area says, "unpredictable reimbursement jeopardizes access to care. Is this your sense?"

Ms. ARCHER. It is absolutely our sense. We see all the time instances where doctors and other health care providers are unwilling to deliver what they deem to be medically necessary services unless the patients are able to pay privately and agree to pay privately for these services. The issue there is that the doctors don't want to be held financially liable for a Medicare denial, even if that denial is wrong.

The problem here is that the doctors, if they are delivering a service that they believe is medically reasonable and necessary, shouldn't be allowed to shift the burden to the patient. If the service is medically reasonable and necessary, Medicare should be paying. If the service is not reasonable and necessary, the doctor shouldn't be delivering it.

But we have this sort of mix going on now where the doctors think it's necessary or they say they think it's necessary. They shift the burden to the patient, financial burden to the patient, and the patient has to assume liability for a procedure that Medicare should be paying for if it is reasonable and necessary or they shouldn't be receiving if it's not reasonable and necessary.

Chairman WYDEN. Do you find—I remember this from my days when I was co-director of the Gray Panthers—that seniors in those kinds of instances are often very reluctant to bring it up with the physician as well because they may have a good relationship with their doctor. They may worry that no one else in town is a specialist in that area.

So, even in an instance like you describe where you have got a medically unnecessary claim, that very often the older person will just say, oh, I'll try to figure out a ways to pay the bill rather than try to get a refund.

Ms. ARCHER. We see that all the time. Patients are very reluctant to jeopardize their relationships with their doctors. They often come to us only after they've terminated their relationship with the doctor. If they come to us during the course of treatment by a particular doctor, they usually don't want us to intervene and just want our comments and our opinions about the agreements their doctors are asking them to sign.

Chairman WYDEN. I think this is another reason to get older people out of the Medicare reimbursement process. There has got to be a better way to go.

Not just older people, but I get probably a call once every 3 weeks that goes something like this: It's Ron. I know you spent a lot of years working with the Gray Panthers, and I can't figure out my mother's Medicare bills. I'm a lawyer or I'm an accountant, and I can't figure out the Medicare bills. What do you suggest I do? I mean, are we going to get a handle on this reimbursement morass or is this just going to go on forever?

Ms. ARCHER. I think that in the course of the last few years it's gotten a little bit easier for patients to understand their Medicare bills, mainly because now there are limits on what doctors can charge them, and there is a little square box at the top of their Medicare statement telling them the maximum amount they owe their doctors under Federal law. But I think we can do a lot more to simplify the system.

Chairman WYDEN. What else would you like? Again, from my experience, everybody always used to call it the Medicare migraine, this kind of Medicare-induced headache brought about from trying to wade through the paper. What else would you like to see be done to simplify the Medicare reimbursement process?

Ms. ARCHER. Well, I think the main point is to get seniors out of the loop. But I think that your point and the GAO's study indicate, and we certainly agree, that HCFA should be nationalizing medical policy to a much greater extent, that there is just no justification for one carrier to be claiming that a procedure is experimental and another to be covering that service as medically necessary or for people in California to need six chiropractic visits and in New York for people in the same condition to need four. It just doesn't make any sense right now. So, I think there needs to be a little bit more coherency in the system.

Chairman WYDEN. Do you and other senior citizen advocacy organizations ever get to see carrier diagnostic screenings and medical policies?

Ms. ARCHER. I think most of them are secret. We don't see them. We hear about them. Sometimes the doctors learn about them after they've received or they've heard about denials. But we don't understand what they are or how they work in large part.

Chairman WYDEN. So we've got a situation where someone like yourself who runs a program doesn't get to see much in terms of these diagnostic screens, and the irony is I don't think most Americans have any sense of this.

Congress passes laws and amendments to deal with Medicare, and then agencies have rules, and people, I think, are somewhat conversant in that. But then we have to go much further down to look at these carrier practices to see where decisions are actually

made about paying claims and providing some kind of certainty. I guess what you're saying is that people like you don't get to see them and what—maybe a handpicked group of doctors that get consulted by local carriers see it, and that's about it?

Ms. ARCHER. Right.

Going back to your earlier point about accountability, it's very hard to know as an outsider what's going on with these carriers and whether, in fact, the consultations with the medical advisors resulted in legitimate screens or not. Because we often don't even know what those screens look like.

Chairman WYDEN. You have been a very fitting way to finish this up. Because ultimately until this process works for older people we have got to stay at it. I think that the Health Care Financing Administration has tried to offer the judgment today that, well, denial rates may not be very high in some areas and say, well, that's that.

I think that you and the General Accounting Office and many of the leaders in the health field have really said that's not the appropriate measure, that there ought to be more logical explanation as to why there is a differential of 800 to 900 times between carriers for a particular service. That if screens, these insurance company semisecret screens—and I put the emphasis more on secret rather than semi—are going to be the principal tool in America for deciding whether somebody gets a Medicare claim paid there has got to be a much stronger system of watchdogging how those decisions are made. I don't think it's good enough to just say, well, fine, let's have a few private insurance carriers go off and talk to a handful of doctors.

If these screens are going to be the ball game, then maybe what the Congress ought to step in and legislate is if a carrier is going to set up a screen they should talk to somebody like you who works firsthand in this area.

Ms. ARCHER. It's more that they maybe should be public, that people should be aware of what they are.

We should also be doing more reporting of doctors who the carriers believe are not filing claims that are legitimate. I mean, if the carriers are denying claims on 5 percent of the provider community—because they believe 50 percent of the claims denied are from 5 percent of the provider community—because they believe those providers are billing for services that are medically unnecessary, I think it's incumbent upon Medicare to let the seniors know what it thinks about these providers.

Chairman WYDEN. What has been the experience of nonphysicians on these screening discussions? Have you heard of any of them participating?

Ms. ARCHER. What has been the experience of who?

Chairman WYDEN. I'm looking at one of the descriptions of a physician advisory committee that presumably works on setting up one of these screens. Do you know of anybody who has participated in one of these?

Ms. ARCHER. I don't. No.

Chairman WYDEN. But the most important thing to you, and the antiseptic here in your opinion, would be to make public the

screens so that at least people like yourselves would have some certainty and you could communicate it to older people.

Ms. ARCHER. I think the most important thing is the consistency. The second most important thing is some kind of publication of this information so that there's a forum for discussing the legitimacy of the screens which there really isn't at that time in many instances. Third, to the extent that the Health Care Financing Administration is detecting patterns of abuse among particular providers they should also be protecting the consumers and alerting them to these patterns of abuse.

Chairman WYDEN. It says in these instructions from HCFA that Medicare beneficiaries are supposed to be involved in this. I wonder if these carriers actually do contact older people. You don't know if they have?

Ms. ARCHER. I don't know how they develop these screens.

Chairman WYDEN. According to HCFA instructions, there ought to be discussions with older people, coalitions for the elderly. I have worked in these areas, and I have never heard of anybody being asked either.

You have been very helpful. I want you to know that I hope that we can get out the message of what the defense fund is trying to say on this issue because I'm very concerned that come the next Congress a lot of my colleagues on both sides of the aisle are going to say, well, Medicare is where the money is, and just start at it in an indiscriminate kind of fashion.

What we have learned this morning is that, for example, until you get down to where the real decisions are made in the setting of these screens and claims review and the like it really isn't possible to try, as you say, to make sure that the right claims are paid and the right claims are denied and to protect the interests of seniors and taxpayers. So——

Ms. ARCHER. I couldn't agree with you——

Chairman WYDEN. Anything you would like to add further?

Ms. ARCHER. No, thank you.

Chairman WYDEN. We commend you for the excellent work that you all do at the defense fund.

The subcommittee is adjourned.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned, subject to the call of the chair.]

APPENDIX

Medicare Beneficiaries Defense Fund

Statement of

Diane Archer, Esq.

Executive Director

Medicare Beneficiaries Defense Fund

Before the

United States House of Representatives

Committee on Small Business

Subcommittee on Regulations, Business Opportunities

and Technology

December 19, 1994

Testimony of Diane S. Archer
Executive Director, Medicare Beneficiaries Defense Fund, Inc.

Thank you for the opportunity to address the Committee on Small Business' Subcommittee on Regulation, Business Opportunities and Technology.

My name is Diane Archer and I am the Executive Director of the Medicare Beneficiaries Defense Fund. MBDF is a national, not-for-profit organization that works to assure equal access to quality health care for seniors and people with disabilities on Medicare. MBDF provides seniors and people with disabilities on Medicare with direct assistance through a nationwide telephone hotline program. This year alone, we received more than 15,000 calls concerning Medicare and related health insurance problems on our telephone hotline. Through our direct services to Medicare patients, MBDF identifies systemic failings and limitations in the Medicare program, recommends changes to correct them, educates the public about Medicare issues, empowers seniors and people with disabilities to help themselves and, where necessary, takes corrective action on their behalf.

At the outset, we want to emphasize that the Medicare program currently works extremely well for the vast majority of Medicare patients who are in relatively good health. Our clients, however, tend to be the Medicare patients in poor health, with limited resources. And perhaps the largest single problem these Medicare patients face is securing access to necessary health care services and appropriate coverage for these services. Medicare routinely but erroneously denies and reduces

benefits for physician services, hospital care, skilled nursing facility care and home health care. According to recent HCFA statistics, more than three-quarters of all claimants who appeal initial Medicare coverage denials receive coverage. Unfortunately, however, only two percent of the seniors and people with disabilities denied coverage have the information or resources necessary to appeal and correct erroneous Medicare claims denials.

We believe that Congress should view this reversal data as evidence that the Medicare system wrongly denies coverage on a routine basis and that HCFA has not acted to correct systemic problems in claims administration. The resulting Medicare system all too often imposes a horrifying dilemma on countless seniors and people with disabilities on fixed incomes: they can either forego necessary medical care or risk impoverishment by agreeing to pay privately for the services that Medicare wrongly refuses to cover.

We believe that a significant factor in the unacceptably high rate of erroneous claims denials is the fact that HCFA permits the 60 Medicare carriers and intermediaries and the 141 Medicare HMOs to develop different sets of medical policies and standards for determining whether Medicare will provide coverage for a particular medical service.

HCFA could impose uniform and detailed coverage standards on each of its regional carriers, fiscal intermediaries and Medicare

HMOs. The application of these uniform standards throughout the Medicare system would be subject to oversight, review and correction by a single federal agency with the responsibility for implementing the federal Medicare statute. Instead, within a broad framework established by the Medicare statute, HCFA regulations and national coverage decisions, the individual Medicare carriers which administer Part B claims and the fiscal intermediaries which administer Part A claims are generally free to establish their own coverage and claims denial criteria -- deciding whether services are experimental and establishing norms through utilization and diagnostic screens to make an initial determination whether services are excessive or inappropriate given a particular diagnosis. Moreover, the Medicare system allows each of the 141 Medicare HMOs to develop their own coverage standards within the broad framework established by HCFA regulations and national coverage determinations.

The resulting quiltwork of conflicting Medicare policies means that Medicare will cover certain medical services in some regions and deny coverage for the same services in others. Even more distressing, with the emergence of Medicare HMOs, the same medical service performed by the same provider in the same community may or not be denied Medicare coverage depending on whether the patient is enrolled in a Medicare HMO and which Medicare HMO the patient chooses. This trend is certain to increase in the future as the health care industry shifts to a

managed care system and more and more seniors and people with disabilities are enrolled in Medicare HMOs.

The General Accounting Office report released today amply documents the substantial variation in denial rates among carriers for medical necessity. Although the GAO report does not discuss whether this patchwork system of Medicare coverage affects health care delivery, our experience suggests that carrier discretion to develop their own medical policies in fact undermines equitable access to quality health care for seniors and people with disabilities. In particular, we believe that HCFA's failure to establish uniform coverage policies for all 34 regional carriers has contributed to three fundamental problems with the Medicare system.

First, the ability of carriers to develop independent medical policy makes it all the harder to understand what services are covered. Without the variations in medical policy, Medicare is extraordinarily difficult for most people to understand. With the variations, even we at MBDF -- who focus exclusively on Medicare issues -- are hard pressed to stay on top of the different constantly changing coverage policies throughout the country. The system simply does not permit Medicare patients in ill health any reasonable opportunity to understand their health care rights.

Second, MBDF's experience in assisting hundreds of seniors and people with disabilities suggests that carrier medical

policies tend to discourage physicians from delivering necessary care. We know from both utilization studies and our own caseload, for example, that Medicare home health care practice patterns vary wildly in the 50 states. In Tennessee, for example, 117 out of every 1000 Medicare patients received an average of 100 covered home care visits in 1992. In New York, however, 57 of every 1000 Medicare patients received an average of only 38 visits in 1992. We have attached a chart prepared by the Center for Health Care Law reflecting these practice patterns as Appendix A.

This extreme variation in home health care usage is, we believe, the direct result of the independent and conflicting medical policies that are designed and enforced by different fiscal intermediaries in Tennessee and New York respectively. Home health agencies are not paid to bear the financial and administrative costs of challenging initial coverage denials by fiscal intermediaries. They are thus not inclined to provide home health care services where they know they will receive a first level coverage denial from a fiscal intermediary -- even when they stand a good chance of overturning that initial denial on appeal. Uniform national standards would at least assure equitable delivery of covered home health services throughout the country.

Our anecdotal experience with Part B Medicare claims suggests a similar problem. Like home health agencies, doctors

are not generally inclined to assume the financial and administrative burden of fighting carrier utilization screens and medical policies on a case-by-case basis. As a result, many doctors require Medicare patients to sign waivers agreeing to pay privately for medical services if the Medicare carrier denies coverage. I have attached examples of such waivers in Appendix B. This growing practice of requiring patients to sign these waivers forces seniors and people with disabilities to choose between necessary medical care and risk of financial ruin. That, we submit, is not how this country's Medicare system should work. Again, this problem would be reduced significantly if HCFA established uniform medical policies for all carriers and carefully oversaw, reviewed and corrected individual carrier policies to ensure consistency in health care delivery.

Third, the wide discretion afforded individual carriers actually prevents HCFA from establishing appropriate Medicare coverage policies for some medical services. In the absence of uniform national standards, for example, HCFA advised us that it lacked any administrative mechanism to require Blue Cross of Western New York to cover a particular combination of medical services -- a Swan-Ganz catheterization and an A-line insertion -- even though every other carrier in the country provides Medicare coverage for this combination. As a result, MBDF clients who received these services in upstate New York had to appeal their coverage denials in downstate New York before a

different carrier that covered this particular combination of medical services. Many people who did not understand their rights and who did not know to transfer their cases downstate to MBDF simply went without coverage.

Finally, HCFA's failure to establish uniform national coverage policies has greatly magnified each of these problems for the more than two million Medicare patients now enrolled in HMOs. In contrast to Medicare's carriers and fiscal intermediaries, Medicare HMOs typically maintain no standard policy for denying claims. Many of our clients do not understand that they are entitled to appeal a Medicare HMO decision to deny them services; the HMO may never issue a written denial; and even when HMO patients appeal and win Medicare coverage, they do not always receive the medical care they need. Our client Mrs. K was enrolled in a Medicare HMO but could not secure necessary chiropractic care because her HMO refused to cover the service. MBDF appealed the HMO's denial of care and an Administrative Law Judge ordered Mrs. K's HMO to provide her chiropractic services. The HMO still refused to provide her chiropractic services and Mrs. K, tired of fighting, had no choice but to disenroll from the HMO in order to secure the care she needed.

The adoption of uniform national coverage policies would allow MBDF and other senior advocates to resolve the growing number of HMO problems such as Mrs. K's on a systemic basis rather than HMO by HMO.

In short, if equitable access to quality health care is to be anything more than an empty promise, then HCFA must standardize coverage criteria in both the HMO and fee-for-service settings. There is no compelling reason why medical policy should be substantially different in different parts of the country and in different HMOs. Instead, carriers, fiscal intermediaries and HMOs should only be able to establish their own medical policies in exceptional circumstances for a temporary period, where they are testing new coverage guidelines or they detect patterns of abuse that HCFA has not yet addressed through national policy. In those circumstances, HCFA must ensure that Medicare carriers use these medical policies rationally and effectively while HCFA develops appropriate national coverage standards.

I have included specific recommendations with my written testimony which I ask to be included in the record.

Recommendations

1. Medicare's medical policy should be national and should apply to Medicare-contracting HMOs as well as carriers and fiscal intermediaries. To the extent carriers and intermediaries use utilization screens, HCFA should develop them and ensure they are applied properly.
2. Seniors and people with disabilities should be removed from the Medicare reimbursement process. They currently are

forced to fight bureaucratic battles with Medicare which they often cannot fight without time, energy, and the documentation and assistance needed from their physicians. Patients who cannot successfully navigate the reimbursement and appeals process are forced to forego much-needed coverage. MBDF understands that HCFA is working to remove Medicare patients from the reimbursement process and to make Medicare an efficient system for them; we applaud its efforts to do so.

3. There must be greater accountability among Medicare carriers, fiscal intermediaries and HMOs and greater incentives for insurance carriers to process claims correctly and for HMOs to deliver all necessary covered care.
4. Medicare staff who assist patients must have a solid mastery of the Medicare program or the ability to find out answers quickly and accurately.
5. Consumer information and education must improve in content and increase in volume before seniors and people with disabilities can truly understand their rights. MBDF applauds the Congressional appropriation of $10 million for health insurance counseling services both this year and last. The $40,000 contract we hold through the New York State Office for the Aging helps us serve more than 1700 callers a month. Unfortunately, $10 million a year is not

nearly enough to serve all the Medicare patients requiring assistance.

The best health care system we can offer our citizens is one that provides necessary care and coverage for that care in a fair and equitable manner. Congress must work from this premise as it scrutinizes the Medicare program, including its HMOs, and contemplates the future of health care in this country. Seniors and people with disabilities on Medicare suffer considerably from arbitrary claim denials. As a group, they are shortchanged millions of dollars. Individually, they are suffering physically, financially, and emotionally and foregoing necessary treatment.

Appendix A

CENTER FOR HEALTH CARE LAW
519 C STREET, N.E., STANTON PARK, WASHINGTON, D.C. 20002-5809
(202) 547-5262 FAX: (202) 547-7126

WILLIAM A. DOMBI, ESQ.,
Director

JAMES E. MURRAY, ESQ

The most recent state-level Medicare utilization data is for 1992.

Medicare Home Health Agency Services by State, 1992							
	Visits Per Patient	Visits Per 1,000 Enrollees	Users Per 1,000 Enrollees		Visits Per Patient	Visits Per 1,000 Enrollees	Users Per 1,000 Enrollees
US	53.1	3,767	71.0	MS	94.3	11,786	125.0
AK	36.8	1,295	35.2	MT	43.0	2,438	56.7
AL	93.8	9,086	96.9	NC	50.2	3,459	69.0
AR	61.7	4,816	78.1	ND	35.9	1,890	52.7
AZ	47.8	2,093	43.8	NE	35.5	1,765	49.6
CA	33.8	2,075	61.4	NH	57.4	4,710	82.1
CO	43.2	2,721	62.9	NJ	33.8	2,102	62.1
CT	66.4	5,510	83.0	NM	37.1	2,057	55.4
DC	36.1	2,130	59.1	NV	56.4	2,905	51.5
DE	43.5	3,032	69.7	NY	37.7	2,163	57.3
FL	65.7	6,079	92.5	OH	40.1	2,441	60.9
GA	87.5	7,815	89.3	OK	71.9	5,262	73.2
HI	27.8	668	24.0	OR	36.3	1,842	50.8
IA	35.7	1,794	50.3	Pos	29.6	1,283	43.4
ID	40.1	2,330	58.1	PA	36.6	3,130	85.6
IL	40.5	2,864	70.7	RI	63.9	4,889	76.5
IN	53.9	3,173	58.9	SC	53.0	3,368	63.5
KS	41.8	1,959	46.9	SD	27.0	969	35.9
KY	57.0	4,059	71.2	TN	100.0	11,717	117.2
LA	86.4	9,444	109.3	TX	66.4	4,924	74.1
MA	71.6	6,802	95.0	UT	76.5	5,661	74.0
MD	34.2	2,207	64.6	VA	40.6	2,537	62.4
ME	62.3	4,900	78.6	VT	64.8	7,345	113.3
MI	35.1	2,496	71.1	WA	33.8	1,873	55.4
MN	32.1	1,216	37.9	WI	34.7	1,712	49.3
MO	40.8	3,462	84.8	WV	41.7	2,598	62.4
				WY	57.5	3,063	53.3

Appendix B

has advised me that the procedures to be performed, listed below, may not be fully reimbursed by Medicare as they may not be considered medically necessary and reasonable by Medicare. Although Medicare may reduce / deny payment for the procedures, I have advised Island Medical Associates, P.C. to proceed with the services and I will assume full responsibility for payment.

_____	50590-22	ESWL Lithotripsy	$10,000
_____	50590-51	ESWL Lithotripsy Multiple Treatment or Bilateral Treatment	$11,500
_____	74000-22	KUB Radiological Films @	$100.00
_____	76000-22	Fluoroscopy	$155.00
_____	09004-22	Extra Electrodes @	$400.00
_____	52332-22	Cystoscopy & Stent Insertion	$1800.00
_____	53670-22	Catheterization	$155.00
_____	52310-22	Cystoscopy & Stent Removal	$1500.00
_____	53620-22	Dilation	$250.00
_____	50394-22	Retrograde Pyelogram	$395.00
_____	74410-22	IVP	$395.00
_____	09008-22	Stone Displacement Catheter	$225.00
_____	09003-22	Double J Stent	$250.00
_____	09006-22	Catheter	$65.00
_____	09009-22	Uroradiometric Catheter	$185.00
_____	09007-22	Braasch Bulb Catheter	$230.00
_____	52330-22	Stone Manipulation	$3500.00
_____	52335-22	Ureteroscopy	$3500.00
_____	99071-22	Disposable Ureteroscope	$500.00
_____	71020-22	Chest Xray	$95.00
_____	50392-22	Introduction of Intracatheter	$3000.00
_____	74426-22	Nephrostogram	$385.00

Date: 8/25/93 Signature: _____

Medicare: _____

I made $950 cc out of pocket payments already before being advised by secondary insurance carrier to question their method of collection - where do I stand. What are my rights -

Dear Mr. .

We are participants in the Medicare program. However, Medicare has refused to pay Prostatic Ultrasounds.

The fee for this proceedure is $ 300 and you will be responsible for this amount.

Patient's Signature _____

Date 6/14/91

CHIROPRACTIC GROUP

EXPLANATION OF CHIROPRACTIC MEDICARE BENEFITS

Dear Chiropractic Patient:

In accordance with regulations established by the Federal Government, the Medicare program does provide coverage for chiropractic care but with certain limitations.

Medicare requires that each patient have current x-rays of the spine and that these x-rays must show evidence of a spinal subluxation. Medicare does not cover the cost of the x-ray even though it requires that this office take them. Also not covered by Medicare are any therapies, supports, supplements, examinations or other services that your Doctor of Chiropractic may determine are necessary for the proper care of your condition or illness.

Your condition may require, in our judgement, more treatments than are allowed by Medicare. This office can apply for additional treatment coverage by submitting a 'medical necessity statement' on your behalf. While your case will be reviewed by Medicare, we cannot guarantee or predict how this review will be decided in your particular care.

Any visits over the 12-visit parameter that Medicare determines are not covered will be the financial responsibility of the patient.

I have read and understand this statement.

PATIENT'S NAME:_____

PATIENT'S SIGNATURE _____

DATE:_____

WITNESS NAME:_____

WITNESS SIGNATURE:_____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

6._____ 11._____

January 17, 1994

Sample Physician Advance Notice to Beneficiary

Medicare has determined that the following statements would satisfy the satutory requirements for the physician's advance notice and the beneficiary's agreement to pay for both assigned and unassigned claims. Note that Medicare stipulates that the patient's advance agreement to pay for services which subsequently may be determined to be "medically unnecessary" is an integral part of the advance notice.

Beneficiary Notice

Medicare will only pay for services that it determined to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment for .....for the following reasons.....
give reason for your belief

Beneficiary Agreement

I have been notified by my physician that he or she believes that, in my care, Medicare is likely to deny payment for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

(9).....
Medicare Beneficiary

Date:_____

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Regulation, Business Opportunities, and Technology, Committee on Small Business, House of Representatives

For Release on
Delivery Expected at
10:00 a.m., EST
Monday
December 19, 1994

MEDICARE PART B

Factors That Contribute to Variation in Denial Rates for Medical Necessity Across Six Carriers

Statement of Terry E. Hedrick
Assistant Comptroller General
Program Evaluation and Methodology Division

GAO/T-PEMD-95-11

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to be here to share with you the results of our ongoing work on the Medicare Part B claims processing system. My statement is based upon our report entitled Medicare Part B: Regional Variation in Denial Rates for Medical Necessity, which is being issued today. Our report has two objectives--to determine the extent of carrier variability in denial rates for lack of medical necessity and (2) to identify and examine factors that may contribute to such intercarrier variation. To develop this information, we analyzed a 5-percent sample of 1992 and 1993 Medicare Part B data on claims processed by six Medicare carriers for 74 services that were either expensive or heavily utilized. The carriers included in this study were California Blue Shield (jurisdiction: Northern California), Transamerica Occidental Life Insurance (jurisdiction: Southern California), Connecticut General Life Insurance Company (jurisdiction: North Carolina), Blue Shield of South Carolina, Illinois Blue Cross and Blue Shield, and Wisconsin Physicians' Service.

Our analysis showed that the magnitude of carrier denial rates for Medicare Part B claims was generally low and persistent for 2 consecutive years, although rates for some services shifted. Medical necessity denial rates for 74 services across six carriers varied substantially. The primary reason was that certain carriers used computerized screening criteria for

specific services while others did not. Thus, carriers' selecting the services to be screened and their determining the stringency of the screen criteria probably account for a significant proportion of the variability in denial rates. Further, a small proportion of the providers accounted for 50 percent of the denied claims. To a lesser degree, the varying interpretation of certain national coverage standards across carriers, differences in the way carriers treated claims with missing information, and reporting inconsistencies also helped explain the variation in carrier denial rates. We make specific recommendations to the Health Care Financing Administration to address these issues.

Before turning to our specific findings, let me briefly discuss the program and the process by which carriers determine medical necessity.

The Medicare program, authorized under title XVIII of the Social Security Act, is a nationwide entitlement program to provide health care benefits to persons 65 years old or older, certain disabled beneficiaries, and most persons with end-stage renal disease. Since its inception, the program has grown considerably: The number of people with coverage increased from 19 million in 1967 to over 35 million in 1993. Currently, about 96 percent of those eligible for Medicare are enrolled. HCFA administers the Medicare program and establishes the regulations

and policies under which it operates.

In accordance with section 1842 (42 U.S.C. 1395u) of the Social Security Act, HCFA contracts with 34 private insurance carriers to process and issue benefit payments on claims submitted under Part B coverage. Carriers are required to process claims in a timely, efficient, effective, and accurate manner. During fiscal year 1993, carriers processed about 576 million Part B claims submitted by about 780,000 physicians and 136,000 suppliers.

Section 1842 of the Social Security Act mandates that carriers pay only for services that are covered and that they reject a claim if they determine that the services were not medically necessary. In fiscal year 1993, carriers denied 112 million Part B claims in whole or in part (19 percent of all claims processed) for a total of $17 billion (which represented 18 percent of all billed charges, a figure unchanged from the previous year). Services deemed not medically necessary constituted about 9 percent of the dollar amount denied by carriers.

Although most claim denials are the result of routine administrative checks made during claims processing (for example, denials for duplicate claim submissions or ineligible claimants), a portion of denials are the result of coverage determinations.

Coverage under Medicare is determined by three criteria: Medicare law, national coverage standards developed by HCFA, and local coverage standards developed by individual carriers.

According to section 1832 (42 U.S.C. 1395k) of the Social Security Act, Medicare Part B covers a wide range of health services, such as physician services, outpatient hospital services, the purchase of durable medical equipment, prosthetic devices, and laboratory tests. At the same time, the act limits podiatric, chiropractic, and dental services and specifically excludes some categories of service, such as routine physical checkups and cosmetic surgery.

Although carriers make most coverage decisions, HCFA has set national coverage standards for some specific services. Where HCFA has issued a national coverage decision, carriers are expected to enforce it. Although national coverage standards are for the most part straightforward, some standards may require clarification or interpretation. In such instances, carriers are advised to consult with a HCFA regional office, which may in turn ask the HCFA central office for guidance.

In the absence of national coverage standards, HCFA has, consistent with Medicare law, given carriers the discretion to develop and apply their own medical policies based on local standards of medical practice. Carriers often "must decide

whether the service in question appears to be reasonable and necessary and therefore covered by Medicare." HCFA has given carriers broad latitude in this area--that is, it has given them primary responsibility for defining the criteria that are used to assess the medical necessity of services. Such local medical policies allow carriers to target specific services that may need greater scrutiny. For example, local medical policies may be developed in response to excessive utilization of a service or inappropriate billing patterns.

Concerning medical necessity, you asked us to assess whether carriers differ significantly in denial rates for lack of medical necessity for Medicare Part B claims and to identify factors that contribute to intercarrier variations. In response to your request, we analyzed 1992 and 1993 Medicare Part B data on claims processed by six Medicare carriers for 74 services that were either expensive or heavily utilized. We computed denial rates for services that were determined by carriers to be not medically necessary using a definition of denial rate as the number of services denied for medical necessity divided by the number of services allowed multiplied by 1,000. In our report, we present the results of our analysis of these denial rates and examine five factors that may contribute to the observed rate differentials among the six carriers.

Now let me turn to the results of our study.

FINDINGS

To determine whether there were significant differences with regard to medical necessity denial rates among six carriers across 74 expensive or heavily utilized services, we examined the (1) magnitude, (2) variability across carriers, and (3) changes of denial rates for 1992-93.

First, within this group of 74 services, denial rates were generally low--a finding that was consistent across all six carriers. Most services had denial rates less than 10 per 1,000 services allowed.

Second, the denial rates showed notable variability across the carriers. For example, the denial rates for a chest x-ray varied between 0.1 and 90.2 per 1,000 allowed. In the latter case, almost one chest x-ray was denied for every 10 allowed.

Third, variation persisted across years, although rates changed for some specific services. Services that had high denial rates in 1992 also tended to have high rates in 1993. Conversely, services with low denial rates in 1992 also were generally low in 1993.

WHY THIS VARIATION IS IMPORTANT

Carrier differences in the treatment of claims denied for reason of medical necessity is an important issue, one that has implications for appropriate management of Medicare expenditures as well as consistency of treatment of providers and Medicare beneficiaries.

FACTORS THAT CONTRIBUTED TO INTERCARRIER VARIATION IN DENIAL RATES

We identified five factors that may help explain the variation in denial rates across carriers: (1) differences in how carriers implemented the prepayment screens, (2) the varying interpretation of certain national coverage standards across carriers, (3) differences in the way carriers treated claims with missing information, (4) reporting inconsistencies, and (5) aberrant billing practices of a minority of providers.

Carriers Differed in How They Implemented the Prepayment Screens

To gauge the effect of medical necessity screens on carrier denial rates, we asked the carrier with the highest denial rate for medical necessity for 5 selected services to identify the specific reason for denial for a small sample of 15 to 20 claims. In this way, we were able to identify the key screens that most

directly caused the claims to be denied.

First, with respect to computerized prepayment screens, we found that the types of services screened for medical necessity varied across carriers. For example, only one of the six carriers (Southern California) screened echocardiography and myocardial perfusion imaging services. Carrier denial rates were also associated with the presence or absence of a screen. Although the presence or absence of a screen was not sufficient to account for all variation in denial rates across carriers, it is important to note that the highest denial rates were invariably associated with screens. Similarly, while three carriers screened multichannel blood test services, the types of screens they used varied. For example, the North Carolina carrier used a utilization screen, the Wisconsin carrier used a diagnostic screen, and the Illinois carrier used both.

We also found that even when carriers screened the same service, they used different criteria for suspending claims. For example, the first 12 visits to a chiropractor for spinal manipulation to correct a subluxation must meet certain basic HCFA coverage criteria, such as that an x-ray demonstrating the spinal problem must be available, signs and symptoms must be stated, and the precise level of subluxation must be reported. The carriers we contacted had all incorporated these criteria into their medical policies for chiropractic spinal manipulation.

HCFA requires that carriers assess the necessity of visits in excess of 12 per year, but carriers diverged in how they assessed such treatments. One carrier stated that, after 12 visits, additional documentation on medical necessity would be required. Another carrier based the number of additional visits allowed on the injured area of the spine. When that number of additional visits was reached, this carrier required additional documentation from the provider. Still another carrier stated that, while it reviewed visits beyond 12, it usually did not require additional documentation until the 30-visit mark.

Carriers Differed in How They Interpreted Certain National Coverage Standards

Second, we learned from carriers that they sometimes differed in their interpretations of national coverage standards. Because some standards leave key elements of the policy undefined, carriers interpreted and applied the same standards in different ways.

In 1993, Transamerica Occidental Life, in coordination with HCFA, conducted an internal study of claims that it had processed for 17 different services for which Transamerica had higher denial rates in 1992 than other carriers. This study uncovered some problem areas that relate to the implementation of national coverage standards. For example, Transamerica found differences

across carriers in how they assessed chest x-ray and mammography claims. This suggests that, at least with respect to chest x-rays and mammographies, carriers had difficulty distinguishing whether these procedures were performed for screening or diagnostic purposes. This difficulty may also extend to other types of test procedures.

Thus, issuing a national coverage standard for a service is not sufficient to ensure consistency of application. While it is probably not feasible for HCFA to develop coverage standards that anticipate every conceivable circumstance under which a claim might be filed, chest x-ray and mammography are coverage issues that appear to be in need of further clarification by HCFA.

Carriers Differed in How They Treated Incomplete Claims

A third factor relates to the manner in which carriers treated claims with billing errors or missing information. For example, if a carrier's medical policy required that the provider indicate the diagnosis when submitting a claim for a particular type of service and the claim lacked this information, the carrier had several options. The carrier could (1) return the claim to the provider, (2) "develop" the claim (that is, delay adjudication and try to obtain the required information by contacting the provider), or (3) deny the claim.

If the first option was exercised and the claim was returned, it was as if the claim had never been submitted. If the second option was exercised and the carrier received the requisite information, then the claim was adjudicated. If the third option was selected and the carrier denied the claim, the provider had either to resubmit the claim or go through the appeal process to obtain payment for this service. The resubmitted claims might well be paid, but the carrier's records would still show that the claim had been denied.

Although carriers had several ways of processing incomplete claims, the option they selected for any given claim depended on such factors as the cost incurred to develop the claim, the capability of their computer systems, and special instructions from HCFA. For example, a carrier may have chosen to develop incomplete claims involving surgical procedures while denying incomplete claims involving chiropractic treatments, or the carrier may have rejected claims missing beneficiary health insurance numbers while developing claims with missing provider identification numbers.

Because the preceding examples highlight only a handful of the numerous possible combinations that may have been used to process claims with incomplete information, it is difficult to characterize any one carrier's approach, much less systematically compare carrier differences in this respect. However, it is

reasonable to infer that carriers that emphasized claim denial over claim development (or rejection) for incomplete claims may have had higher denial rates for medical necessity than carriers that did not.

HCFA has examined this issue in an internal working document and has asked its Office of the General Counsel for advice that would bring consistency to the way that claims lacking basic information are processed. In brief, HCFA's recommendation calls for eliminating the denial option for incomplete claims. Claims that lack the requisite information would be returned or deleted, and the provider or supplier would be notified.

We believe that standardizing the process of handling incomplete claims would improve the accuracy of carrier workload statistics by making them more comparable across carriers.

Carriers Differed in How They Reported the Reason for a Claim Denial to HCFA's Central Database

A fourth factor is that because carriers used different computer systems to process claims, their internal action codes--which indicate the reason for denying a service--were not identical. To facilitate carrier comparisons, HCFA has required that each carrier translate its own set of internal action codes into 10 broad categories when transmitting data to HCFA's central

database. However, because HCFA has given carriers little guidance in performing this task, carriers have been uncertain as to how denials should be classified for reporting purposes. This, in turn, has affected the reliability of estimated denial rates.

Transamerica, in its internal study of denial rates, identified two service categories that carriers have tended to use interchangeably: "noncovered" and "medically unnecessary" care. The study found that "medically unnecessary" was used to classify denials for 3 service codes (of 17 studied) that should have been classified as "noncovered" care.

Our analysis corroborates Transamerica's findings. We found that while reporting misclassifications of this type does not affect the actual outcome of claims, it can affect the reliability of estimated denial rates for certain services. Still, we found significant intercarrier variability in denial rates whether we looked at noncovered care, medical necessity, or both categories combined. Reporting inconsistencies of this type affect HCFA's ability to accurately monitor program operation activities. This is an area where additional guidance from HCFA could improve the quality of the data it collects.

A Few Providers Account for a Significant Proportion of the Variation in Carrier Denial Rates

To test the fifth factor, the hypothesis that the billing practices of a few aberrant providers account for a significant proportion of the variation in carrier denial rates, we examined 4 services that exhibited wide variation in carrier denial rates for medical necessity. We defined providers with aberrant billing practices in two ways: (1) those with the highest denial rates or (2) those with the largest number of denials. We then calculated a carrier's denial rate for a service excluding the contribution of the top 5 percent of providers (in terms of both rate and total) to determine whether variations in denial rates were still observable. We found that the top 5 percent of providers contributed substantially to carrier denial rates for each of the 4 services. However, excluding these providers did not eliminate the variation across carriers.

Furthermore, in analyzing the 16 services with denial rates above 90 per 1,000 services allowed, we found that a small minority of providers, between 2 and 11 percent, accounted for 50 percent of services denied for lack of medical necessity (and thus were responsible for the bulk of denials).

CONCLUSIONS

While we cannot explain differing patterns of denials--for example, they may result from unnecessary services being disproportionately offered by a few providers, differences in patient characteristics, variations in billing practices, different local standards of medical practice, or other factors--further examination of the reasons for differences are warranted.

We are not in a position to address the question of whether high or low denial rates for individual services were appropriate. Low denial rates are desirable from the standpoint that they imply less annoyance and inconvenience for providers and beneficiaries. However, low denial rates are desirable only insofar as providers do not bill for medically unnecessary services.

What is clear from our work is that further analysis of denial rates can provide useful insight into how effectively Medicare carriers are managing program dollars and serving beneficiaries and providers. Since the carriers have funding constraints that limit the number of claims they can examine on a prepayment basis, it is important that they use the most effective and appropriate screens.

We believe that HCFA could improve its oversight capabilities by actively monitoring data on carrier denial rates and improving the reliability of the data that it collects. Data on denial rates are useful for identifying inconsistencies across carriers in the way that claims are assessed for medical necessity. This information, in turn, could be used to identify services that certain carriers have found to have billing problems. In addition, for services that are more uniformly screened by carriers, variation in denial rates could indicate that carriers are using different screen criteria, which raises issues of appropriateness and effectiveness. Finally, data on denial rates could be used to construct a profile of the subpopulation of providers that have a disproportionately large number of denials, which might suggest a solution to this problem.

We recommend that, to improve its oversight of the Medicare Part B program, HCFA

-- issue instructions to carriers on how to classify the reason for denial when reporting this information;

-- analyze intercarrier screen usage (including the stringency of screen criteria), identify effective screens, and disseminate this information to all carriers; and

-- direct carriers to profile the subpopulation of providers responsible for a disproportionate share of medical necessity denials in order to devise a strategy for addressing this problem.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions that you or members of the Committee may have.

United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Regulation, Business Opportunities, and Technology, Committee on Small Business, House of Representatives

December 19, 1994

MEDICARE PART B

Regional Variation in Denial Rates for Medical Necessity

GAO/PEMD-95-10 Printed copies of this document will be available shortly

GAO United States
General Accounting Office
Washington, D.C. 20548

Program Evaluation and
Methodology Division

B-257799

December 19, 1994

The Honorable Ron Wyden
Chairman, Subcommittee on
Regulation, Business Opportunities,
and Technology
Committee on Small Business
House of Representatives

Dear Mr. Chairman:

You asked us to assess whether there are significant differences among carriers in denial rates for lack of medical necessity for Medicare Part B claims and to identify factors that contribute to intercarrier variations. Carrier differences in the treatment of claims denied for reason of medical necessity is an important issue, one that has implications for the appropriate management of Medicare program expenditures as well as the consistency of treatment of providers and beneficiaries.

In response to your request, we analyzed 1992 and 1993 Medicare Part B data on claims processed by six Medicare carriers for 74 services that were either expensive or heavily utilized. We computed denial rates for services that carriers determined to be not medically necessary. This report presents the results of our analysis of these denial rates and identifies and examines five factors that contributed to the observed rate differentials among the six carriers.

RESULTS IN BRIEF

Although denial rates for lack of medical necessity for 74 expensive or heavily utilized services were generally low, there were substantial variations across the six carriers we

examined.[1] Moreover, these variations were persistent for most services from 1992 to 1993, even though the denial rates for some specific services may have increased or decreased.[2] Five factors help explain carrier variations in denial rates. For one, they stemmed primarily from carriers' differing prepayment screens--that is, some carriers screened specific services while others did not, and those that screened the same service used different criteria. For another, only 5 percent of providers accounted for 50 percent of the denied claims. Three other factors were the varying interpretation of certain national coverage standards across carriers, differences in the way carriers treated claims with missing information, and reporting inconsistencies.

MEDICARE COVERAGE CRITERIA

In accordance with section 1842 (42 U.S.C. 1395u) of the Social Security Act, the Health Care Financing Administration (HCFA) contracts with 32 insurance carriers to process and issue benefit payments on claims submitted under Medicare Part B coverage. Carriers are required to process claims in a timely, efficient, effective, and accurate manner. During fiscal year 1993, carriers processed about 576 million Part B claims submitted by about 780,000 physicians and 136,000 suppliers.

Section 1842 of the Social Security Act provides that carriers pay only for services that are covered and that they reject a claim if they determine that the service was not medically necessary. In fiscal year 1993, carriers denied 112 million Part B claims in whole or in part (19 percent of all claims processed) for a total of $17 billion in denied claims (which represented 18 percent of all billed charges, a figure unchanged from the previous year). Services deemed not medically necessary constituted about 9 percent of the dollar amount denied by carriers. A claimant (provider or beneficiary) who is dissatisfied with a carrier's claims decision has the right to appeal.

Although most claim denials are the result of routine administrative checks made during claims processing (for example,

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[1]The following six carriers were included in this study: California Blue Shield (jurisdiction: Northern California), Transamerica Occidental Life Insurance (jurisdiction: Southern California), Connecticut General Life Insurance Company (jurisdiction: North Carolina), South Carolina Blue Shield, Illinois Blue Cross and Blue Shield, and Wisconsin Physicians' Service.

[2]See U.S. General Accounting Office, Medicare Part B: Inconsistent Denial Rates for Medical Necessity Across Six Carriers, GAO/T-PEMD-94-17 (Washington, D.C.: March 29, 1994).

denials for duplicate claim submissions or ineligible claimants), a significant portion of denials are the result of coverage determinations. Coverage under Medicare is determined by three criteria: Medicare law, national coverage standards developed by HCFA, and local coverage standards developed by individual carriers.

According to section 1832 (42 U.S.C. 1395k) of the Social Security Act, Medicare Part B covers a wide range of health services, such as physician services, outpatient hospital services, the purchase of durable medical equipment, prosthetic devices, and laboratory tests. At the same time, the act limits or excludes certain services: It places limits on podiatric, chiropractic, and dental services and specifically excludes some categories of service, such as routine physical checkups and cosmetic surgery. Medicare law is best viewed as a framework for making coverage determinations: It is not, as HCFA has observed, "an all-inclusive list of specific items, services, treatments, procedures or technologies covered by Medicare."[3]

Recognizing that the law could not anticipate all possible coverage issues, the Congress provided the following guidance to HCFA for making decisions:

> "Notwithstanding any other provisions of this title, no payment may be made under part A or part B . . . for any expenses incurred or items of services . . . which . . . are not reasonable and necessary for the diagnosis or treatment or illness or injury or to improve the functioning of a malformed body member."[4]

For a service to be covered, it must meet

> "a test of whether the service in question is 'safe' and 'effective' and not 'experimental'; that is, whether the service has been proven safe and effective based on authoritative evidence, or alternatively, whether the service is generally accepted in the medical community as safe and effective for the condition for which it is used."[5]

Although carriers make most coverage decisions, HCFA has set national coverage standards for some specific services, the guidelines of which are found in the Medicare Carriers Manual,

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[3]54 Fed. Reg. 4304. (Preamble to proposed rules that, although not yet final, are generally looked to for guidance.)

[4]Title XVII of Social Security Act, sec. 1862(a)(1)(A)[42 U.S.C. 1395y (a)(1)(A)].

[5]54 Fed. Reg. 4304.

the Medicare Coverage Issues Manual, and other program publications.[6] Where HCFA has issued a national coverage decision, carriers are expected to enforce it. Although national coverage standards are for the most part straightforward, some standards may require clarification or interpretation. In such instances, carriers are advised to consult with a HCFA regional office, which may in turn ask the HCFA central office for guidance.

In the absence of national coverage standards, HCFA has, consistent with Medicare law, given carriers the discretion to develop and apply their own medical policies based on local standards of medical practice. Since national coverage standards have been issued for only a small portion of all services, carriers often "must decide whether the service in question appears to be reasonable and necessary and therefore covered by Medicare."[7] HCFA has given carriers broad latitude in this area --that is, it has given them primary responsibility for defining the criteria that are used to assess the medical necessity of services. Such local medical policies allow carriers to target specific services that may need greater scrutiny. For example, local medical policies may be developed in response to excessive utilization of a service or inappropriate billing patterns.

To implement medical policies, carriers develop prepayment screens that suspend a subset of claims for manual review. Screens are computer algorithms that use certain claim information (such as diagnostic code or frequency of services performed) to channel certain types of claims to examiners for further review. The criteria used to flag claims for medical review are less exhaustive than the criteria used in making the final determination.

For example, a screen for chiropractic treatment may suspend claims of beneficiaries who have received more than 12 treatments within the past year. At this point, the suspended claims are reviewed by claims examiners, who make a determination based on medical policy. A carrier's medical policy defines the conditions under which chiropractic treatments beyond the threshold are medically necessary. It is, however, important to note that the proportion of claims that carriers review for medical necessity is determined by the amount of money available to HCFA for allotment to carriers for the purpose of medical review. In fiscal year 1994, HCFA allotted enough funds for 5

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[6]For a general description of how HCFA makes coverage decisions on new medical technologies, see U.S. General Accounting Office, Technology Assessment and Medical Coverage Decisions, GAO/HEHS-94-195FS (Washington, D.C.: July 1994).

[7]54 Fed. Reg. 4304.

percent of claims to be medically reviewed.

Despite the importance of carrier vigilance over Medicare claims, budgetary constraints have led to a decrease in program safeguard activities such as prepayment screening of claims for medical necessity. The proportion of claims that are reviewed for medical necessity has decreased from 20 percent of all claims in 1989 to 5 percent in 1994. Because carriers now have fewer resources to review the appropriateness of claims, it is essential that carriers use what resources they do have in the most effective way possible. Yet, we found that HCFA has not compiled information, nor does it have a systematic method that would allow it to assess the adequacy of current carrier safeguard controls.[8]

We conducted our study between April and November 1994 in accordance with generally accepted government auditing standards. See appendix I for a description of our analytical methodology.

ANALYSIS OF DENIAL RATES

This section presents the results of our analysis of 1992-93 medical necessity denial rates for six carriers across 74 expensive or heavily utilized services. We examined the (1) magnitude, (2) variability across carriers, and (3) annual changes of denial rates for 2 consecutive years.

Denial Rates Were Generally Low

Table 1 summarizes 1993 denial rate information from appendix III (appendix II gives 1992 data) and shows the frequency distribution of denial rates for the 74 services across six carriers. This table shows that within this group of 74 services, denial rates were generally low--a finding that was consistent across all carriers. For example, the Northern California carrier had 47 services with a denial rate of zero, 19 services with a denial rate of between 1 and 10, 6 services with a rate of between 11 and 100, and 2 services with a denial rate of over 100 per 1,000 services allowed.[9] Furthermore, the

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[8]U.S. General Accounting Office, Medicare: Funding and Management Problems Result in Unnecessary Expenditures, GAO/T-HRD-93-4 (Washington, D.C.: February 1993).

[9]Services that exhibited high denial rates included those of the following types: ambulance service, eye examination, chiropractic treatments, myocardial perfusion imaging, PTCA, and duplex scan of extracranial arteries. Services that exhibited minimal variation in the range of denial rates across carriers were those that pertained to digestive procedures (endoscopy and colonoscopy); nursing facility services; office and outpatient

Southern California carrier, which had the largest number of services with denial rates over 10 per 1,000 allowed, still had a majority of services (46 of 74) with denial rates of less than 10 per 1,000 services allowed.

Table 1: Distribution of Top 74 Services by Denial Rate and Carrier, 1993

Denial rate per 1,000 services allowed[a]	Number of services						Total
	Northern California	Southern California	North Carolina	South Carolina	Illinois	Wisconsin	
0	47	8	15	52	38	36	196
1 to 10	19	38	48	22	20	28	175
11 to 100	6	23	7	0	14	9	59
100+	2	5	4	0	2	1	14
Total	74	74	74	74	74	74	444

[a]We classified three codes with no allowed services as 0 for the purpose of this tabulation. Denial rates were rounded to the nearest whole number.

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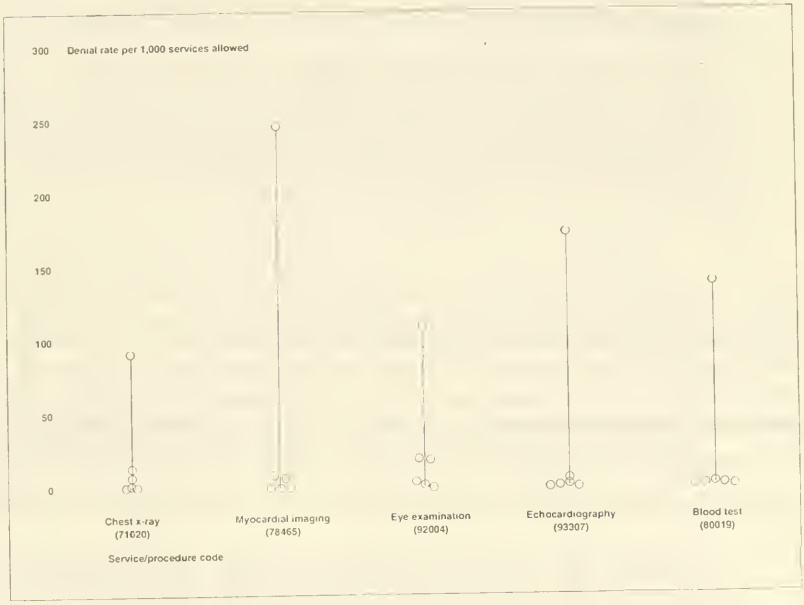
visits; and cardiovascular, musculoskeletal, anesthesia, and urinary procedures.

Denial Rates for Medical Necessity Varied Across Carriers

The denial rates for 1992 and 1993 show notable variability across six carriers. Figure 1, which displays 1993 carrier denial rates for 5 different services, illustrates this point. For example, the range of denial rates across carriers for a chest x-ray varied between 0.1 and 90.2 (per 1,000 services allowed).[10]

[10]The formula for calculating denial rates is as follows: denial rate = (number of services denied for reason of medical necessity) / (number of services allowed) * 1,000. We used the number of allowed services in the denominator rather than the number of submitted services because the latter includes services denied for other reasons (for example, duplicate line item) and thus would add spurious variation to our estimate.

Figure 1: Denial Rates for Medical Necessity Across Six Services, 1993


300
Denial rate per 1,000 services allowed
250
200
150
100
50
0
Chest x-ray (71020)
Myocardial imaging (78465)
Eye examination (92004)
Echocardiography (93307)
Blood test (80019)
Service/procedure code

Carrier Denial Rates for 1992 and 1993 Were Stable For Most Services

The denial rates for at least two thirds of each carrier's services did not significantly change between 1992 and 1993. In general, the magnitude of carrier denial rates was persistent for 2 consecutive years. Services that had high denial rates in 1992 also tended to have high rates in 1993. Conversely, services with low denial rates in 1992 also were generally low in 1993.[11] (See table 2.)

Table 2: Change in Denial Rates for the Top 74 Services by Carrier, 1992-93

Change in denial rate[a]	Northern California	Southern California	North Carolina	South Carolina	Illinois	Wisconsin	Total
Increased	12	14	18	2	14	2	62
Decreased	4	7	1	5	3	20	40
No change	58	53	55	67	57	52	342
Total	74	74	74	74	74	74	444

[a]A chi-square test of statistical significance was used to test whether 1992 rates differed from 1993 rates. Rate differences significant at $p < 0.01$ were considered to have changed between years.

For two jurisdictions--South Carolina and Wisconsin--the number of services that had decreased denial rates in 1993 exceeded the number of services for which rates increased. Conversely, four carriers--Northern California, Southern California, North Carolina, and Illinois--had more services whose denial rates significantly increased than decreased. For Northern California, Southern California, and Illinois, the difference in the number of services with higher denial rates in 1993 was slight, from 7 to 11 services. However, denial rates for the North Carolina carrier significantly increased between 1992 and 1993 for 18

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[11]For example, Southern California had a denial rate of 83.2 for nonemergency ambulance service (code A0150) in 1992 and a rate of 81.2 in 1993. The difference between denial rates for these 2 years is 2 and is not statistically significant. In other words, the Southern California carrier's denial rate for this ambulance code did not decrease significantly in 1993, and the difference between these 2 years is likely to be due to chance variation. We used a chi-square test of statistical significance to test whether 1992 rates differed from 1993 rates. Rate differences significant at $p < 0.01$ were considered to have changed between years.

services; the denial rate was significantly decreased for only 1 service.

FACTORS THAT CONTRIBUTED TO INTERCARRIER VARIATION IN DENIAL RATES

The significant differences in denial rates for medical necessity across carriers give rise to the following question: What accounts for the variations in denial rates? To address this question, we met with carrier representatives and HCFA officials, who identified five factors that could help explain the variation in denial rates across carriers.

Carriers Differed in How They Implemented Prepayment Screens

The Medicare program has since its inception acknowledged the existence of regional variations in medical practice standards and has sought to accommodate these differences in adjudicating claims. One practical consequence of this policy is that HCFA has delegated to carriers the authority to determine whether a rendered service was medically necessary. Making such determinations requires that carriers first develop a local medical policy. Computer screens are used to suspend a subset of claims, which are then reviewed by claims examiners, who in turn follow local medical policy in making their determinations.[12]

Utilization and diagnostic screens are two of the more common types of screens.[13] Utilization screens measure the number of times a service has been performed against a standard (for example, services per year), and diagnostic screens compare the diagnosis listed on a claim with a defined set of diagnoses that

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[12]We did not examine whether differences in the criteria used in carrier medical policies affect denial rates. However, HCFA has acknowledged the need to promote consistency in medical policy across carriers and has undertaken the following initiatives to promote consistency: (1) developing a database that allows carriers to share information on medical policies, (2) establishing a technical advisory committee for each carrier that informs the carrier of current issues and technological developments in the medical community, and (3) distributing copies of model medical policy and encouraging carriers to use this model as a guide for developing their own policies.

[13]Carriers have a limited number of autoadjudicating computer screens. Such screens do not suspend claims for manual review but, rather, make the final determination of medical necessity. That is, claims not meeting certain criteria are automatically denied without being manually reviewed by claims examiners.

would usually warrant performance of that service.[14]

Differences in the way that carriers use screens can affect the variability of denial rates in two ways. First, in the absence of an applicable local medical policy or a coverage directive from HCFA to assess the validity of a claim, carriers usually assume that a claim is valid and thus should be approved. It follows that, given comparable billing patterns, a carrier with a screen in place for a specific medical service will deny more claims than a carrier without such a screen in place.[15] Carriers differ in the number of services they screen; we reported earlier that the total number of local screens carriers used in 1988 ranged from 5 to 177.[16] Second, different carriers screening the same service may use different criteria to suspend claims. Thus, although two carriers may screen the same service for medical necessity, their respective criteria may result in differing denial rates.

To gauge the effect of medical necessity screens on carrier denial rates, we asked the carrier with the highest denial rate for medical necessity for 5 selected services to identify the specific reason for denial for a small sample of 15 to 20 claims

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[14]For example, with regard to utilization screens, if a carrier's medical policy stated that only one office visit for eye exam per year is medically necessary, the carrier might construct a screen that would suspend a beneficiary's claims for eye examinations that exceed this limit. Diagnostic screens compare the diagnosis listed by the provider on a claim with a set of diagnoses determined by the carrier to indicate the medical necessity of performing a service.

[15]A recent demonstration project sponsored by HCFA underscored this point. Additional funds were allocated to four carriers for the purpose of improving their systems of medical review. Participating carriers used these funds to upgrade their computer systems, develop additional medical policies, and conduct more medical reviews. These improvements led to significant Medicare savings, in part caused by the carriers' appropriately denying a greater number of billed services. This project showed that savings in Medicare expenditures could be achieved by improving and expanding medical review activities. See U.S. General Accounting Office, Medicare: Greater Investment in Claims Review Would Save Millions, GAO/HEHS-94-35 (Washington D.C.: March 1994).

[16]U.S. General Accounting Office, Medicare: Improving Quality of Care Assessment and Assurance, GAO/PEMD-88-10 (Washington, D.C.: May 1988), p. 119.

denied for lack of medical necessity.[17] In this way, we were able to identify the key screens that most directly caused denial. We selected the 5 services because carrier denial rates for each one exhibited significant variation. For each service, we selected the carrier with the highest denial rate and determined the reason for the denial: x-ray and multichannel blood test (Illinois), myocardial perfusion imaging and echocardiography (Southern California), and opthalmologic exam (Wisconsin).

For example, for the automated multichannel blood test, the Illinois carrier had a denial rate of 138.9 per 1,000 services allowed in 1993, while the other carriers had negligible denial rates of 0, 0.1, 0.5, 1.4, and 1.7. After examining a sample of claims, the Illinois carrier concluded that the majority of its denials for reason of medical necessity resulted from a joint utilization and diagnostic screen. That is, a provider in the Illinois carrier's jurisdiction could order this type of blood test for a patient up to two times per year with no condition attached. On the third and subsequent tests, however, the carrier checked the appropriateness of the test against a set of diagnostic codes specified by its local medical policy. If the diagnostic codes on the claim matched codes on this list, the service was approved. Conversely, if a diagnosis was not provided or did not match the accepted codes, the claim was denied and returned to the provider. The provider could then resubmit the claim with a different diagnostic code if appropriate.

We then asked the other carriers (Northern California, Southern California, North Carolina, South Carolina, and Wisconsin) if they had similar utilization and diagnostic checks to assess the medical necessity of multichannel blood tests. Their responses indicated that two carriers used only a diagnostic screen and the remaining three did not have either a utilization or a diagnostic screen for this service. The carriers' responses for this service, as well as for the 4 other services selected for analysis, are summarized in table 3.

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[17]Because the computer systems of most carriers can retrieve claim records for only the preceding 12 to 18 months, we sampled claims from the last quarter of 1993.

Table 3: Pattern of Carrier Screen Use and Denial Rates, by Selected Services, 1993[a]

Service and procedure code	Northern California		Southern California		North Carolina		South Carolina		Illinois		Wisconsin	
	Screen	Denial rate	Screen	Denial rate	Screen	Denial rate	Screen	Denial rate	Screen	Denial rate	Screen	Denial rate
Echocardiography (93307)	None	1.7	Diagnostic[b]	173.3	None[c]	1.1	None[d]	4.4	None	0	None	0
Myocardial perfusion imaging (78465)	None	0	Diagnostic[b]	248.4	None	6.4	None[d]	6.0	None	0	None	0
Chest x-ray (71020)	Diagnostic[a]	7.6	Diagnostic[b]	14.6	Diagnostic	1.2	None	0.2	Diagnostic[b]	90.2	Diagnostic[b]	0.1
Multichannel blood test (80019)	None	0.1	None	1.7	Utilization	0.5	Utilization	1.4	Utilization + diagnostic[b]	138.9	Diagnostic[b]	0
Ophthalmologic exam (92004)	Diagnostic[a]	19.2	Diagnostic	4.2	Diagnostic	1.2	None	0	Utilization + diagnostic[b]	19.6	Diagnostic[b]	108.4

[a]Services that were not screened by carriers could have denial rates greater than zero because of postpayment review or other reasons. Edits for bundling and duplicate line items are not considered to be utilization screens in this table.

[b]The screen autoadjudicates.

[c]Carrier requires diagnostic code but does not require a specific one

[d]South Carolina also reported screens for codes 93307 and 78465; however, they were implemented on December 13, 1993, and November 18, 1994, respectively, and thus could not much have influenced 1993 denial rates.

Variation From the Presence of a Prepayment Screen

We found that the types of services screened for medical necessity varied across carriers. For example, as shown in table 3, only one of the six carriers (Southern California) screened echocardiography and myocardial perfusion imaging services. Similarly, while four carriers screened multichannel blood test services, the types of screens they used varied. For example, the North Carolina carrier used a utilization screen, the Wisconsin carrier used a diagnostic screen, and the Illinois carrier used both.

Table 3 also provides evidence that carrier denial rates were associated with the presence or absence of a screen. For two services, echocardiography and myocardial perfusion imaging, the only carrier (Southern California) that had screens in place had much higher denial rates. While denial rates greater than zero do not always imply the presence of a medical necessity screen (some medical necessity denials may stem from postpayment review activities), denial rates are higher when a carrier has a screen.

For the 3 other services--chest x-ray, multichannel blood test, and opthalmologic exam--the relationship between screening and carrier denial rates was less clear cut. With respect to multichannel blood test, it is possible that the reason the Illinois carrier had the highest denial rate stemmed from the fact that it used two types of screens, consisting of both a utilization and a diagnostic check, while the other carriers either had no screen (Northern California, Southern California, and South Carolina) or had only a diagnostic check (North Carolina and Wisconsin). This explanation, however, is less satisfactory when attempting to account for carrier variation in denial rates for chest x-rays and ophthalmologic exams. In sum, although the presence or absence of a screen was not sufficient to account for all variation in denial rates across carriers, it is important to note that the highest denial rates were invariably associated with screens.

Variations From Differences in the Stringency of the Screen Criteria

Beyond the simple presence or absence of a screen, the stringency of the screen criteria can also contribute to variation in denial rates across carriers by suspending a greater or lesser number of claims that are then subject to a medical review. We found that, even when screening the same service, carriers used different criteria for suspending claims. For example, the first 12 visits to a chiropractor for spinal manipulation to correct a subluxation must meet certain basic HCFA coverage criteria, such as the following: An x-ray demonstrating the spinal problem must be available, signs and symptoms must be stated, and the precise level of subluxation must be reported. The six carriers had all

incorporated these criteria into their medical policies for chiropractic spinal manipulation. HCFA requires that carriers assess the necessity of visits in excess of 12 per year, but carriers diverged in how they assessed such treatments. One carrier stated that, after 12 visits, additional documentation on medical necessity would be required. Another carrier based the number of additional visits allowed on the injured area of the spine. When that number of additional visits was reached, this carrier required additional documentation from the provider. Still another carrier stated that, while it reviewed visits beyond 12, it usually did not require additional documentation until the 30-visit mark.

Carriers Differed in How They Interpreted Certain National Coverage Standards

While we anticipated variation in denial rates on account of differences in carriers' implementation of screens, we expected less variation to result from carriers' differing interpretations of national coverage standards. However, we learned that carriers interpreted and applied the same standards in different ways because some standards leave key elements of the policy undefined.

In 1993, Transamerica Occidental Life, in coordination with HCFA, studied claims that it had processed for 17 different services for which Transamerica showed variation in denial rates in 1992 among the six carriers.[18] The following discussion highlights some problem areas uncovered by the Transamerica study that relate to the implementation of national coverage standards.

Although national coverage standards allow Medicare carriers to pay for diagnostic tests, these standards significantly restrict particular tests for routine screening. Hence, in determining whether a claim should be paid by Medicare, carriers must judge whether the tests were performed for diagnostic or screening purposes. Making such judgments is often difficult, especially

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[18]The services were ambulance service (A0010 and A0020), chiropractic (A2000), cataract removal (66984), chest x-ray (71020), mammography (76091), surgical pathology (88305), percutaneous transluminal coronary angioplasty (92982), echocardiography (93307), Doppler echocardiography (93320), duplex scan of extracranial arteries (93880), and hospital care (99222, 99231, 99233, 99238, 99283, and 99332). HCFA provided Transamerica with a sample of claim numbers drawn from the data set used in our preliminary analysis of denial rates. Claims were extracted from Transamerica's computer system and then examined to determine the reason why a claim was originally denied.

for certain types of tests.[19] Transamerica, for example, found differences across carriers in how they assessed chest x-ray and mammography claims. With regard to chest x-rays, the Transamerica study reported the following:

> "There is a continued trend toward diagnostic screening for asymptomatic patients which we feel necessitates a formal policy. There is also wide variation among carriers as to the necessity for pre-operative diagnostic testing, and whether it falls within the 'medical necessity' coverage of the program. Review of various carriers' policy indicates that some deny as 'routine physical examination,' and not as a medical necessity denial. HCFA needs to clarify their position on this issue so there is more consistency on a national basis."[20]

Similarly, the Transamerica study reported difficulty in implementing HCFA's coverage guidelines for mammographies:

> "HCFA needs to re-evaluate its screening mammography billing and coverage requirements. Many screening services are being performed by nonscreening centers under the nonscreening procedure code. This may reflect a lack of, or inaccessibility to, screening mammography centers. There are also differences among carriers as to what constitutes a screening test. Some of the encounter codes used by HCFA as an indication for screening are also being used for diagnostic tests. Further clarification is needed."[21]

Findings from the Transamerica study suggest that, at least with respect to chest x-rays and mammographies, carriers found it difficult to distinguish whether these procedures were performed for screening or diagnostic purposes. It is likely that this difficulty may extend to other types of test procedures.

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[19]This issue also applies to carriers' determinations of when a test ceases to be experimental. A carrier representative told us that, prior to 1993, her company denied all claims submitted for prostate specific antigen (PSA) test, used for detecting cancer of the prostate. It was considered to be an experimental procedure with low reliability. However, following technical refinements to the test that improved its reliability, PSA gained greater acceptance among physicians as a diagnostic tool. As a consequence, this carrier changed its policy and now pays for PSA testing under certain conditions. Because such decisions are made carrier by carrier, denial rates for certain types of tests are likely to vary across carriers.

[20]Transamerica report to HCFA on denial rates (May 1994), p. 2.

[21]Transamerica, p. 2.

This example illustrates the fact that simply issuing a national coverage standard for a service is not sufficient to ensure consistency of application. While it is probably not feasible for HCFA to develop coverage standards that anticipate every conceivable circumstance under which a claim might be filed, we have identified a coverage issue for chest x-ray and mammography that appears to be in need of further clarification by HCFA.

Carriers Differed in How They Treated Incomplete Claims

The manner in which carriers treated claims with billing errors or missing information affected denial rates. For example, if a carrier's medical policy required that the provider indicate the diagnosis when submitting a claim for a particular type of service, and the claim lacked this information, the carrier had several options. The carrier could (1) return the claim to the provider, (2) "develop" the claim (that is, delay adjudication and try to obtain the required information by contacting the provider), or (3) deny the claim.

If the first option was exercised and the claim was returned, it was as if the claim had never been submitted. If the second option was exercised and the carrier received the requisite claim information, then the claim was adjudicated. If the third option was selected and the carrier denied the claim, the provider had either to resubmit the claim or go through the appeal process to obtain payment for this service.[22] The resubmitted claims might well be paid, but the carrier's records would still show that the claim had been denied. (See table 4.)

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[22]Earlier this year, HCFA surveyed all carriers and concluded that there was significant variation in the way the carriers were treating missing information. We believe that this variation affected denial rates.

Table 4: Options Carriers Used to Process Incomplete Claims

Option	Description
Return, delete, reject	Return: Used for hardcopy claims screened in the mailroom. Rejected claims were never given an internal claim control number; they were physically returned to the provider or supplier. A message was sent to the provider informing it that the claim was not processed. For budgetary purposes, returned claims were not counted as part of the workload. Delete: Used for electronically submitted claims screened by computer. Deleted claims were not given an internal claim control number and a message was sent to the provider or supplier informing it that the claim was not processed. For budgetary purposes, deleted claims were not counted as part of carrier workload. Reject: Claims (both hardcopy and electronic) were assigned an internal claim control number. Claims were entered into the computer system and screened. When missing information was detected, the claim was rejected and a message was sent to the provider or supplier informing it that the claim was not processed. For budgetary purposes, rejected claims were counted as part of carrier workload.
Develop	Carriers suspended judgment on claims and requested missing information from physician or supplier. If requested information was not received within 30 to 45 days, the carrier denied the claim.
Deny	Claim was completely processed through the system and a Medicare explanation-of-benefits message was sent to the claimant (beneficiary or provider) that indicated the basis of the denial. Denied claims were given full appeal rights.

Source: HCFA.

Although carriers had several ways of processing incomplete claims, the option they selected for any given claim depended on such factors as the cost incurred to develop the claim, the capability of their computer system, and special instructions from HCFA. For example, a carrier might have developed incomplete claims involving surgical procedures while denying incomplete claims involving chiropractic treatments, or the carrier might have rejected claims missing beneficiary health insurance numbers while developing claims with missing provider identification numbers.

Because the preceding examples highlight only a handful of the numerous possible combinations that may have been used to process claims with incomplete information, it is difficult to characterize any one carrier's approach, much less systematically compare differences. However, it is reasonable to infer that carriers that emphasized claim denial over claim development (or rejection) for incomplete claims had higher denial rates than carriers that did not.

HCFA has examined this issue and has asked its Office of the General Counsel for advice that would bring consistency to the way that carriers process claims lacking basic information. In brief, HCFA recommends eliminating the denial option for incomplete claims. Claims that lack the requisite information would be returned or deleted and the provider or supplier would be notified.

HCFA has noted that carriers have expressed concern over this proposal. Some carriers are against the elimination of the denial option because (1) it would negatively affect their administrative budget (because deleted or returned claims do not count in their workload statistics), (2) the cost of returning claims can be high, and (3) physicians and suppliers learn how to bill correctly faster when a claim is denied rather than returned. HCFA has responded by asserting that "these costs will be more than offset by fewer denied claims, fewer beneficiary inquiries, and fewer unproductive and expensive appeals." Standardizing the handling of incomplete claims would also improve the accuracy of carrier workload statistics by making them more comparable across carriers.

Carriers Differed in How They Reported the Reason for a Claim Denial to HCFA's Central Database

Because carriers used different computer systems to process claims, their internal action codes--which indicate the reason for denying a service--were not identical. To facilitate comparisons, HCFA has required that each carrier translate its own set of internal action codes into 10 broad categories when transmitting data to HCFA's central database. (See table I.2.) However, because HCFA has given carriers little guidance in

performing this task, carriers are uncertain as to how denials should be classified for reporting purposes. This, in turn, has affected the reliability of estimated denial rates.

Transamerica identified two service categories that carriers have tended to use interchangeably: "noncovered" and "medically unnecessary" care. Its study found that "medically unnecessary" was used to classify denials for 3 service codes (of 17 studied) that should have been classified as "noncovered" care. The misclassified codes related to evaluation and management, ambulance, and cataract services. With regard to ambulance services reported to HCFA as denied for reason of medical necessity, the Transamerica study noted that

> "Changes were made to the reporting classification of messages as a result of our review of Medicare Carriers Manual (MCM) coverage criteria, shifting some of the denials from a medical necessity classification to a coverage classification. There is a great deal of variation among carriers as to whether certain types of ambulance denials are based on medical necessity or coverage. There needs to be more definitive information from HCFA as to how they want the denials to be classified."[23]

We collected and analyzed reporting protocols for the six carriers in this study, and our analysis of these data corroborates Transamerica's findings. (See appendix IV.) We found that while reporting misclassifications of this type does not affect the actual outcome of claims, it can affect the reliability of estimated denial rates for certain services. For this reason, we calculated separate denial rates for "medical necessity" and "noncovered" care and the combined total (see appendixes II and III) and assessed the degree of intercarrier variability for each category of denial. We found significant intercarrier variability for all three types of denial categories. Reporting inconsistencies of this type affects HCFA's ability to accurately monitor program operation activities and is thus an area where additional guidance from HCFA could improve the quality of the data it collects.

A Few Providers Account for a Significant Proportion of the Variation in Carrier Denial Rates

HCFA officials advanced several hypotheses that might help explain variations in carrier denial rates. They focused on provider billing practices as they relate to (1) geographic differences in the level of fraud and abuse, (2) differences across carriers in provider education (that is, efforts aimed at increasing provider awareness of appropriate billing procedures),

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[23]Transamerica report, section headed "Detail Analysis."

and (3) high denial rates caused by the aberrant billing practices of a minority of providers. HCFA has not systematically studied this issue and did not provide us with empirical evidence that would support any of these hypotheses. Using claims data, however, we were able to examine one of these hypotheses--whether the billing practices of a minority of providers were responsible for a disproportionate share of service denials.

To test this hypothesis, we examined four services that exhibited wide variation in carrier denial rates for medical necessity.[24] Although HCFA did not specify the criteria for identifying providers with aberrant billing practices, we assumed that providers that submit claims that are denied at a high rate have aberrant billing practices. However, such providers may not submit enough claims to substantially affect a carrier's denial rate for that service. For this reason, we defined providers with aberrant billing practices in two ways: (1) those with the highest denial rates or (2) those with the largest number of denials. We then calculated a carrier's denial rate for a service excluding the contribution of the top 5 percent of providers (in terms of both rate and total) to determine whether variations in denial rates were still observable.

Table 5 shows that the top 5 percent of providers, in terms of the highest denial rates and highest number of services denied, contributed substantially to carrier denial rates for each of the 4 services. However, excluding these providers did not eliminate the variation across carriers. For example, the actual range of carrier denial rates for echocardiography was 0 to 173.3; excluding the Southern California providers with the highest denial rates, the range was 0 to 154.9; and excluding the Southern California providers with the largest number of services denied, the range was 0 to 63.1. Thus, under both definitions of aberrant billing practice, excluding aberrant practitioners reduced the variability in denial rates for a service but did not eliminate that variation. It is therefore likely that the billing practices of a few providers account for part of the intercarrier variation in denial rates.

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[24]See table 3; we did not analyze provider billing practices with respect to multichannel blood tests because laboratories submitted most of the claims for this service, not the physicians who ordered the test.

Table 5: Carrier Denial Rates for Four Services, Excluding Aberrant Providers

Service and procedure code	Carrier	Denial rate per 1,000 services allowed		
		All providers	Top 5 percent of providers excluded	
			Based on denial rate[a]	Based on total number of denials[b]
Chest x-ray (71020)	Northern California	7.6		
	Southern California	14.6		
	North Carolina	1.2		
	South Carolina	0.2		
	Illinois	90.2	83.0	45.8
	Wisconsin	0.1		
Echocardiography (93307)	Northern California	1.7		
	Southern California	173.3	154.9	63.1
	North Carolina	1.1		
	South Carolina	4.4		
	Illinois	0		
	Wisconsin	0		
Myocardial perfusion imaging (78465)	Northern California	0		
	Southern California	248.4	181.7	148.8
	North Carolina	6.4		
	South Carolina	6.0		
	Illinois	0		
	Wisconsin	0		
Ophthalmologic exam (92004)	Northern California	19.2		
	Southern California	4.2		
	North Carolina	1.2		
	South Carolina	0		
	Illinois	19.6		
	Wisconsin	108.4	67.2	51.9

[a]Denial rate calculated after excluding the 5 percent of providers with the highest denial rates.

[b]Denial rate calculated after excluding the 5 percent of providers with the highest total number of denials.

To further examine provider denial rates for medical necessity, we analyzed the distribution of provider denials for 16 services that had denial rates exceeding 90 per 1,000 allowed. For each service, we calculated the percentage of providers (within a carrier) that accounted for 50 percent of all denials for that service, as well as the percentage of providers with at least one denial. For example, only 6.9 percent of Northern California chiropractors accounted for 50 percent of all denials. Table 6 displays the result of these calculations.

Table 6: Provider Denial Rates for Medical Necessity, 1993[a]

Carrier	Services with denials exceeding 90 per 1,000 services allowed	Percent of providers with at least 1 medical necessity denial[b]	Percent of providers receiving 50 percent of all medical necessity denials
Northern California	A0150	52.5	2.8
	A2000	65.4	6.9
Southern California	78465	58.7	7.9
	92982	19.5	2.3
	93307	53.0	1.5
	93320	49.1	3.0
	93880	52.6	3.1
North Carolina	A0010	73.4	5.6
	A0020	78.1	4.8
	A2000	85.5	10.6
	92982	38.0	6.5
	93549	40.8	6.1
Illinois	A2000	70.5	7.4
	71020	54.2	2.1
Wisconsin	A2000	56.2	6.4
	92004	47.5	4.4

[a]Excludes South Carolina because it does not have medical necessity denial rates greater than 90 per 1,000 services allowed.

[b]Excludes providers that did not submit a claim for a service. Percentages are based on a 100-percent sample of 1993 claims. The method used for determining the denial median was based on the total number of denials a provider received. The percentage of allowed services accounted for by providers with 50 percent of denials was as follows: Northern California, A2000 = 29.7, A0150 = 28.2; Southern California, 78465 = 31.5, 92982 = 3.8, 93307 = 8.7, 93320 = 11.8, 93880 = 19.6; North Carolina, A0010 = 20.8, A0020 = 8.4, A2000 = 29.3, 92982 = 9.9, 93549 = 12.3; Illinois, A2000 = 27.1, 71020 = 17.1; Wisconsin, A2000 = 20.5, 92004 = 16.6.

Our analysis suggests that a small minority of providers, between 1.5 and 10.6 percent, accounted for 50 percent of services denied for lack of medical necessity (and thus were responsible for the bulk of denials). Thus, the screens and medical policies these carriers used to determine the medical necessity of claims primarily affected a relatively small proportion of the provider community. Table 6 also shows that the proportion of providers that had at least one denial varied between 19.5 and 85.5 percent. The latter range suggests that some prepayment screens used to identify inappropriate billing patterns affected a smaller proportion of the provider population than did others.

While we cannot explain differing patterns of provider denials--for example, they may stem from unnecessary services being disproportionately offered by a few providers, differences in patient characteristics, variations in billing practices, or a number of other factors--further examination of the reasons for them is warranted given their potential to explain substantial amounts of variation in denial rates.

CONCLUSIONS

The magnitude of carrier denial rates was generally low and persistent for 2 consecutive years, although rates for some services shifted across years. Medical necessity denial rates for 74 services across six carriers varied substantially. The primary reason for variation in carrier denial rates was that certain carriers used screens for specific services while others did not. Thus, carriers' selecting the services to be screened and their determining the stringency of the screen criteria probably account for a significant proportion of the variability. Further, a small proportion of the providers accounted for 50 percent of the denied claims. To a lesser degree, the varying interpretation of certain national coverage standards across carriers, differences in the way carriers treated claims with missing information, and reporting inconsistencies helped explain variation in carrier denial rates.

We did not attempt to assess whether low or high medical necessity denial rates for individual carriers were appropriate. Low denial rates are desirable from the standpoint that they imply less annoyance and inconvenience for providers and beneficiaries. However, low denial rates are desirable only insofar as providers do not bill for medically unnecessary services.

What is clear from our work is that further analysis of denial rates can provide useful insight into how effectively Medicare carriers are managing program dollars and serving beneficiaries and providers. Since funding constraints limit the number of claims carriers can examine on a prepayment basis, it is

important that they use the most effective and appropriate screens.

We believe that HCFA could improve its oversight capabilities by actively monitoring data on carrier denial rates and improving the reliability of the data that it collects. Data on denial rates are useful for identifying inconsistencies in the way that carriers assess claims for medical necessity. This information, in turn, could be used to identify the services that certain carriers have found to have billing problems. In addition, for services that are more uniformly screened by carriers, variation in denial rates could indicate that carriers are using different screen criteria, which raises issues of appropriateness and effectiveness. Finally, data on denial rates could be used to construct a profile of the subpopulation of providers that have a disproportionately large number of denials, which might suggest a solution to this problem.

RECOMMENDATIONS

We recommend that, to improve its oversight of the Medicare Part B program, HCFA

-- issue instructions to carriers on how to classify the reason for denial when reporting this information;

-- analyze intercarrier screen usage (including the stringency of screen criteria), identify effective screens, and disseminate this information to all carriers; and

-- direct carriers to profile the subpopulation of providers responsible for a disproportionate share of medical necessity denials in order to devise a strategy for addressing this problem.

AGENCY COMMENTS

At your request, we did not obtain agency comments on a draft of this report.

If you or your staff have any questions about this report or would like additional information, please call me at (202) 512-2900 or Kwai-Cheung Chan, Director for Program Evaluation in Physical Systems Areas, at (202) 512-3092. Major contributors to this report are listed in appendix V.

Sincerely yours,

Terry E. Hedrick
Assistant Comptroller General

CONTENTS

ABBREVIATIONS

CWF Common Working File

HCFA Health Care Financing Administration

MCM Medicare Carriers Manual

NCH National Claims History

PSA Prostate specific antigen

OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

We had two objectives in this report. Our first was to determine the extent of carrier variability in denial rates for lack of medical necessity. Our second was to identify and examine factors that contributed to intercarrier variation in denial rates.

SCOPE

To develop the information on denial rates, we analyzed a 5-percent sample of 1992 and 1993 claims for the top 74 medical services processed by six carriers (based on their national ranking in terms of total allowed charges in 1992).[25] We also interviewed HCFA officials and representatives of the following six carriers: California Blue Shield (jurisdiction: Northern California), Transamerica Occidental Life Insurance (jurisdiction: Southern California), Connecticut General Life Insurance Company (jurisdiction: North Carolina), Blue Shield of South Carolina, Illinois Blue Cross and Blue Shield, and Wisconsin Physicians' Service.

In selecting carriers for our analysis, we considered geographic location and the number of claims processed. Our sample included two carriers each from of the Southeast, the Midwest, and the West. We sought to maximize the geographic distance between regions while retaining the potential for examining intraregional variation in claims adjudication. With regard to the number of claims processed, we attempted to obtain a mix of large and small carriers.[26] Table I.1 lists the carriers we visited and the number of claims they processed in fiscal year 1992.

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[25]We abstracted claim information from the physician and supplier portion of the National Claims History database, which serves as a repository for all Medicare claims.

[26]The frequency distribution of number of claims processed by the Medicare carriers is essentially bimodal. That is, there are two large clusters of carriers: those that annually process between 2 and 13 million claims and those that process between 18 and 29 million claims (two carriers processed over 46 million claims each). Our sample includes two carriers from the former cluster and four from the latter.

Table I.1: Claims Processed by Selected Medicare Part B Carriers in 1992

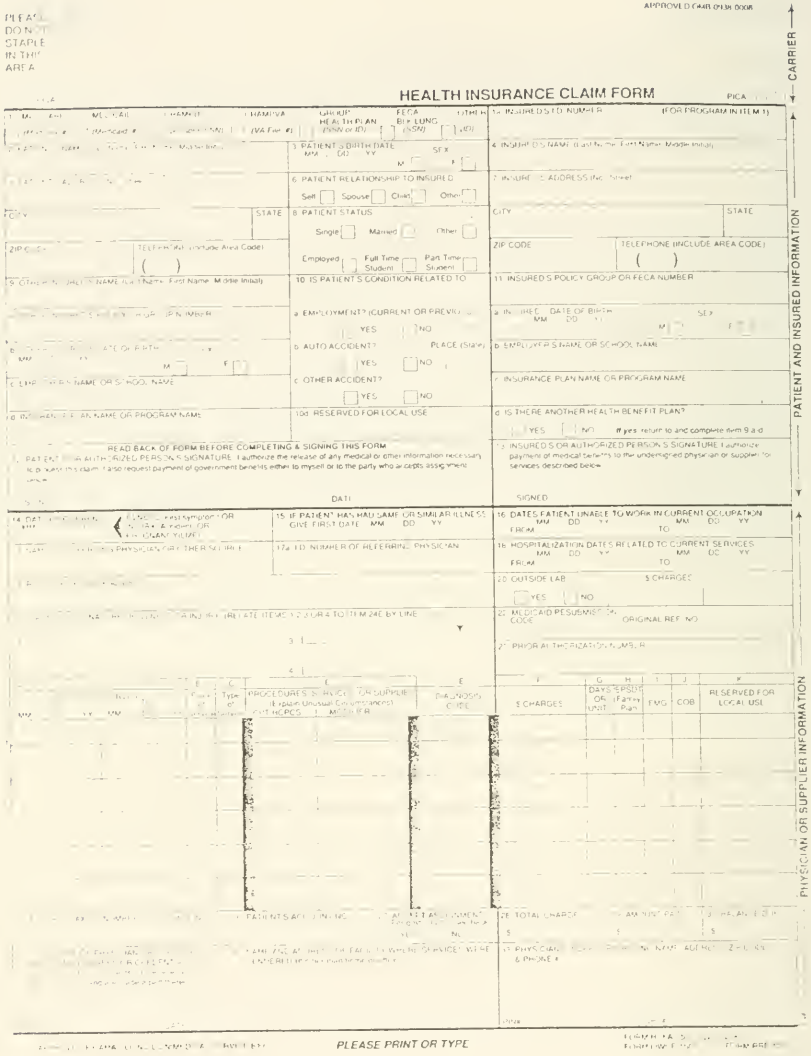
Carrier	Geographic location	Number of claims processed (in millions)
California Blue Shield	West	24
California-Occidental	West	25
Illinois Blue Shield	Midwest	22
Wisconsin Physicians' Service	Midwest	10
North Carolina-Connecticut General	Southeast	18
South Carolina Blue Shield	Southeast	8

Taken together, these six carriers processed about 19 percent of all Part B claims in fiscal year 1992. It should be noted, however, that the judgmental method used to select carriers for this report does not allow us to generalize our findings to the universe of carriers.

METHODOLOGY

We obtained data on denial rates from the National Claims History File, a database maintained by HCFA. It contains a wide variety of claim information, including type of medical service billed and type of action carriers take as a result of the claim adjudication process. On the Medicare claim form, each billed service, or line item, appears as a separate charge with a corresponding five-digit service code that describes the type of service provided. (See figure I.1.) For example, code 71020 refers to a chest x-ray. It is important to note that a Medicare claim can contain submitted charges for more than one service. A claim for a physician's office visit, for example, may also include the charges for laboratory tests performed during the visit. The denial rates presented in this report are based on specific services, not on claims.

Figure I.1: Medicare Part B Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (MEDICARE #) | MEDICAID (MEDICAID #) | CHAMPUS (SPONSOR'S SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? PLACE (State) YES | NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, OR 3 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN#

GRP#

PLEASE PRINT OR TYPE

APPROVED FORM OMB-0938-0008

Each service, or line item, listed on a claim is subject to the carrier's approval or denial. For each service processed, the carrier must indicate whether the claim for service was approved or denied and, if denied, the specific reason for denial. Table I.2 shows the categories of denial that are reported to HCFA's central database.

Table I.2: Reported Reasons for Denying a Medicare Service Claim

Reason	Description
Medically unnecessary	Service denied because it was determined that service was not medically necessary
Noncovered care	Service denied because it was administered under conditions that are not covered by Medicare
Benefits exhausted	Service denied because beneficiary exhausted all Part B benefits or reached the maximum limit of services: the three types of services subject to limitations under Medicare are psychiatric services, occupational therapy, and physical therapy
Invalid data	Claim contained invalid data; for example, the day and month of the service date were transposed, as in 15/9/94. This type of claim should be resubmitted
Multiple submittal	Service denied because submitted charge was duplicated on claim form
Medicare secondary payer	Service denied because Medicare was not the primary payer
Clinical Laboratory Improvement Act	Service denied because it was performed by a noncertified laboratory
Physician ownership denial	Service denied because the physician (or physician's relative) has ownership in the laboratory that performed the service
Data match (Medicare secondary payer cost avoided)	Service denied because Medicare was not the primary payer, discovered through an Internal Revenue Service and Social Security Administration data match
Other	Denials that do not fit into the categories above

We analyzed services that were denied because they were "medically unnecessary." We focused on this type of denial because it reflects, to a greater degree, the effect of carrier discretion in claims assessment. That is, determining medical necessity quite often entails the application of a complicated set of decision rules and may ultimately require the individual judgment of a claims reviewer. In contrast, the other types of denial involve more straightforward criteria that can be applied by means of computerized programs (such as whether charges for the same service appear twice on a claim). We calculated denial rates by summing the number of services denied for medical necessity and dividing the total by the number of services allowed for each of 74 services.[27] We excluded from the analysis services denied for reasons other than medical necessity.

Although Medicare covers more than 10,000 different medical services, relatively few services account for the bulk of Medicare costs. Our analysis was restricted to the top 74 services, based on their national ranking in terms of the total of allowed charges in 1992.[28] In 1992, the top 74 services constituted approximately 50 percent of all Medicare Part B allowed charges. Services that rank high in allowed charges are either frequently performed (for example, office visits) or costly (for example, angioplasty treatments).[29]

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[27]The formula for calculating denial rates is as follows: denial rate = (number of services denied for reason of medical necessity) / (number of services allowed) * 1,000.

[28]The "allowed charge" for a service is set by HCFA. The amount HCFA actually pays is 80 percent of the allowed charge less deductible or co-payment.

[29]Because durable medical equipment and parenteral and enteral claims are currently processed at regional centers, we also excluded such services from our analysis.

APPENDIX II

1992 DENIAL RATES (PER 1,000 SERVICES ALLOWED) FOR MEDICAL NECESSITY AND NONCOVERED CARE BY CARRIER

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
	Anesthesia							
00142	Anesthesia for procedure on eye, lens surgery	Med.	0.0	1.3	5.7	0.0	0.0	17.8
		Cov.	1.2	10.9	5.7	0.8	0.0	18.6
		Total	1.2	12.1	11.4	0.8	0.0	36.4
00562	Anesthesia, procedure on heart, pericardium and great vessels of chest; oxygenator with pump	Med.	0.0	0.0	0.0	0.0	0.0	0.0
		Cov.	2.4	3.4	11.4	0.0	0.0	17.8
		Total	2.4	3.4	11.4	0.0	0.0	17.8
	Muscloskeletal							
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement, with or without allograft	Med.	0.0	4.7	0.0	0.0	0.0	0.0
		Cov.	0.0	9.3	0.0	0.0	0.0	12.0
		Total	0.0	14.0	0.0	0.0	0.0	12.0
27236	Open treatment of closed or open femoral fracture	Med.	0.0	0.0	0.0	0.0	0.0	0.0
		Cov.	0.0	3.7	24.0	0.0	0.0	16.8
		Total	0.0	3.7	24.0	0.0	0.0	16.8
27244	Open treatment of closed or open intertrochanteric	Med.	0.0	0.0	0.0	0.0	0.0	0.0
		Cov.	0.0	16.3	31.4	0.0	0.0	21.9
		Total	0.0	16.3	31.4	0.0	0.0	21.9
27447	Arthroplasty, knee, condyle, and plateau; medical and lateral compartments, with or without patella resurfacing	Med.	0.0	2.9	0.0	0.0	0.0	0.0
		Cov.	0.0	2.9	43.5	0.0	0.0	14.2
		Total	0.0	5.8	43.5	0.0	0.0	14.2
	Cardiovascular							
33512	Coronary artery bypass, 3 coronary venous grafts	Med.	14.6	0.0	0.0	0.0	0.0	0.0
		Cov.	0.0	4.5	6.3	0.0	15.2	54.5
		Total	14.6	4.5	6.3	0.0	15.2	54.5
33513	Coronary artery bypass, 4 coronary venous grafts	Med.	3.9	0.0	0.0	0.0	0.0	0.0
		Cov.	0.0	32.7	30.3	0.0	13.2	35.7
		Total	3.9	32.7	30.3	0.0	13.2	35.7
36415	Routine venipuncture, collection of specimen	Med.	0.2	0.2	0.9	0.2	0.0	0.1
		Cov.	17.8	6.0	15.6	2.5	4.2	10.2
		Total	18.0	9.2	16.6	2.7	4.2	10.3

APPENDIX II

Code	Description	Type[a]	N. Calif.	S. Calif	N.C.	S.C.	Ill.	Wis.
	Digestive							
43235	Upper gastrointestinal endoscopy, including esophagus, stomach, duodenum, or jejunum; complex diagnostic	Med.	0.0	0.9	1.1	0.0	1.8	0.0
		Cov.	0.9	10.2	14.2	2.3	1.8	10.2
		Total	0.9	11.1	15.3	2.3	3.6	10.2
43239	Upper gastrointestinal endoscopy, including esophagus, stomach, and either duodenum or jejunum; for biopsy or collections by brushing	Med.	0.0	1.6	3.7	0.0	2.2	0.0
		Cov.	0.9	6.4	24.9	0.0	0.0	12.8
		Total	0.9	8.0	28.6	0.0	2.2	12.8
45378	Colonoscopy, fiberoptic, beyond splenic flexure, diagnostic, with or without colon decompression	Med.	0.0	0.9	0.0	0.0	0.8	0.0
		Cov.	1.8	6.0	20.3	0.0	1.7	6.2
		Total	1.8	6.8	20.3	0.0	2.5	6.2
45385	Colonoscopy, fiberoptic, beyond splenic flexure, same as above, with removal of polypoid lesions	Med.	0.0	3.7	0.0	0.0	0.0	0.0
		Cov.	1.2	7.5	12.2	0.0	0.0	10.3
		Total	1.2	11.2	12.2	0.0	0.0	10.3
	Urinary							
52000	Cystourethroscopy (separate procedure)	Med.	1.3	2.1	0.0	0.0	3.2	0.0
		Cov.	1.3	8.9	5.8	0.0	2.4	17.0
		Total	2.6	11.0	5.8	0.0	5.6	17.0
52601	Transuretheral resection of prostate, including control of post-op bleeding, complete	Med.	9.0	3.2	0.0	0.0	0.0	0.0
		Cov.	6.0	0.0	21.4	7.8	0.0	12.9
		Total	15.0	3.2	21.4	7.8	0.0	12.9
	Eye and ocular adenxa							
65855	Trabeculoplasty by laser surgery, one or more sessions	Med.	0.0	2.3	0.0	0.0	0.0	0.0
		Cov.	3.8	75.9	9.6	0.0	0.0	74.1
		Total	3.8	78.2	9.6	0.0	0.0	74.1
66821	Discussion of secondary membranous cataract	Med.	0.0	1.0	1.1	0.0	0.0	0.0
		Cov.	0.0	35.3	27.6	0.0	0.5	5.9
		Total	0.0	36.3	28.7	0.0	0.5	5.9
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis	Med.	0.2	10.8	5.5	0.0	1.1	0.0
		Cov.	0.0	31.1	14.1	1.7	0.5	0.7
		Total	0.2	42.0	19.7	1.7	1.6	0.7
	Radiology							
71010	Radiological exam, chest, single view, frontal	Med.	0.5	16.0	4.4	1.0	80.5	1.0
		Cov.	0.5	13.0	12.5	4.2	0.3	17.4
		Total	1.0	29.0	16.8	5.2	80.9	18.4

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Code	Description	Type[a]	N. Calif.	S. Calif	N.C.	S.C.	Ill.	Wis.
71020	Radiological exam, chest, 2 views, frontal and lateral	Med.	0.4	12.4	0.9	0.2	103.2	0.9
		Cov.	1.2	7.0	14.2	11.9	1.3	19.1
		Total	1.6	19.3	15.0	12.2	104.5	20.0
76091	Mammography, bilateral	Med.	0.3	54.0	0.3	0.0	0.0	0.4
		Cov.	1.3	11.9	124.3	28.8	0.2	129.3
		Total	1.5	65.9	124.6	28.8	0.2	129.7
77430	Weekly radiation therapy management, complex	Med.	0.0	1.2	0.0	0.0	0.0	1.6
		Cov.	0.0	5.5	35.6	1.6	75.3	8.2
		Total	0.0	6.7	35.6	1.6	75.3	9.9
78465	Myocardial perfusion imaging	Med.	0.0	261.4	1.5	15.1	0.0	0.0
		Cov.	2.0	4.9	17.0	0.0	0.0	5.9
		Total	2.0	266.3	18.5	15.1	0.0	5.9
	Path/lab							
80019	Automated multichannel test, 19 or more clinical chemistry tests	Med.	1.1	3.5	0.2	2.8	93.8	0.0
		Cov.	28.7	4.7	3.7	8.4	0.0	14.2
		Total	29.8	8.2	3.9	11.2	93.8	14.2
84443	Thyroid stimulating hormone	Med.	0.6	3.4	0.3	4.4	0.0	0.0
		Cov.	26.5	4.6	1.6	5.8	0.1	14.3
		Total	27.1	8.0	2.0	10.2	0.1	14.3
85025	Blood count; hemogram and platelet count, automated and CBC	Med.	0.9	5.2	0.2	0.0	0.0	0.3
		Cov.	27.8	3.7	3.2	7.7	0.0	9.7
		Total	28.7	8.9	3.3	7.7	0.0	10.0
86316	Immunoassay for tumor antigen (for example, prostate specific antigen)	Med.	0.3	3.2	0.4	0.0	0.0	0.0
		Cov.	30.6	4.1	8.2	4.1	0.0	6.5
		Total	30.8	7.3	8.6	4.1	0.0	6.5
88305	Level IV--surgical pathology, gross and microscopic exam	Med.	0.1	19.9	1.5	0.5	0.0	0.7
		Cov.	1.1	19.6	22.7	1.9	0.3	18.4
		Total	1.1	39.5	24.2	2.4	0.3	19.1

APPENDIX II

Code	Description	Type[a]	N. Calif.	S. Calif	N.C.	S.C.	Ill.	Wis.
	Medicine							
90843	Individual medical psychotherapy by a physician, approximately 20-30 minutes	Med.	0.1	14.7	1.6	0.0	0.0	1.0
		Cov.	2.9	12.7	26.4	6.3	7.8	26.4
		Total	3.0	27.4	28.0	6.3	7.8	27.3
90844	Individual medical psychotherapy by a physician, approximately 45-50 minutes	Med.	0.2	9.9	1.0	0.0	0.0	0.7
		Cov.	0.6	15.7	23.4	0.0	35.5	182.1
		Total	0.8	25.6	24.4	0.0	35.5	182.8
92004	Opthalmologic services: medical examination and evaluation	Med.	0.2	5.2	0.4	0.0	1.4	102.2
		Cov.	3.4	11.7	61.6	16.7	3.1	4.7
		Total	3.7	16.9	62.0	16.7	4.5	106.9
92012	Ophthalmologic services: medical exam and evaluation, with initiation or continuation of diagnostic and treatment program	Med.	0.0	1.8	0.5	0.0	1.6	51.5
		Cov.	1.1	22.9	37.6	6.6	8.1	4.2
		Total	1.1	24.7	38.1	6.6	9.7	55.7
92014	Ophthalmologic services: medical exam and evaluation, with initiation or continuation of diagnostic and treatment program	Med.	0.0	2.8	0.9	0.0	2.5	83.5
		Cov.	1.1	12.7	49.0	22.6	4.1	5.6
		Total	1.1	15.6	50.0	22.6	6.6	89.1
92982	Percutaneous transluminal coronary balloon angioplasty, single vessel	Med.	0.0	182.4	29.2	0.0	0.0	33.3
		Cov.	256.3	19.5	58.5	0.0	175.0	0.0
		Total	256.3	202.0	87.7	0.0	175.0	33.3
93005	Electrocardiogram, routine, with at least 12 leads; tracing only, without interpretation and report	Med.	1.0	8.5	0.6	0.0	0.1	0.8
		Cov.	36.8	11.3	42.0	2.8	3.1	21.4
		Total	37.7	19.8	42.6	2.8	3.3	22.2
93307	Echocardiography, real-time with image documentation (2D), with or without M-mode recording, complete	Med.	4.1	140.0	1.2	0.0	0.0	1.5
		Cov.	0.9	41.4	39.3	1.2	0.0	5.2
		Total	5.0	181.4	40.5	1.2	0.0	6.7
93320	Doppler echocardiography, pulsed wave or continuous wave with spectral display, complete	Med.	0.4	88.8	8.1	0.0	0.0	4.8
		Cov.	0.7	31.9	40.2	0.7	5.1	6.2
		Total	1.1	120.7	48.3	0.7	5.1	11.0
93547	Combined left heart catheterization, selective coronary angiography, 1 or more coronary arteries, and selective left ventricular angiography	Med.	0.0	3.0	1.5	0.0	0.0	0.0
		Cov.	0.0	78.2	5.9	0.0	66.4	3.6
		Total	0.0	81.2	7.4	0.0	66.4	3.6
93549	Combined right and left heart catheterization, selective coronary angiography, 1 or more coronary arteries	Med.	0.0	0.0	198.6	0.0	0.0	0.0
		Cov.	0.0	79.1	41.1	0.0	88.5	5.3
		Total	0.0	79.1	239.7	0.0	88.5	5.3

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Code	Description	Type[a]	N. Calif.	S. Calif	N.C.	S.C.	Ill.	Wis.
93880	Duplex scan of extracranial arteries; complete bilateral study	Med.	0.0	124.9	13.6	0.0	0.0	0.0
		Cov.	1.9	15.4	55.9	0.0	1.8	7.2
		Total	1.9	140.2	69.6	0.0	1.8	7.2
	Office or other outpatient services							
99202	Office or other outpatient visit for the evaluation	Med.	0.2	15.9	0.4	0.0	2.7	0.4
		Cov.	10.8	12.6	26.6	5.7	15.0	65.7
		Total	11.0	28.4	27.0	5.7	17.7	66.0
99203	Office or other outpatient visit	Med.	0.7	10.4	0.2	0.0	3.6	1.3
		Cov.	6.8	11.9	30.7	7.6	12.7	87.7
		Total	7.4	22.3	30.9	7.6	16.3	89.0
99204	Office or other outpatient visit	Med.	0.0	8.6	0.0	0.0	4.1	0.0
		Cov.	3.2	9.5	20.5	2.5	13.0	66.5
		Total	3.2	18.1	20.5	2.5	17.1	66.5
99205	Office or other outpatient visit	Med.	0.3	6.98	0.7	0.0	9.3	0.0
		Cov.	1.3	9.4	23.8	3.5	26.6	40.7
		Total	1.6	16.4	24.5	3.5	35.9	40.7
99211	Office or other outpatient visit for the evaluation	Med.	1.2	17.4	0.3	0.0	6.2	20.2
		Cov.	9.3	25.8	25.6	1.1	15.7	31.8
		Total	10.5	43.3	26.0	1.1	21.9	52.0
99212	Office or other outpatient visit	Med.	0.6	7.9	0.5	0.0	5.5	18.4
		Cov.	2.6	27.2	20.3	2.0	8.1	10.8
		Total	3.2	35.1	20.8	2.0	13.6	29.3
99213	Office or other outpatient visit	Med.	0.4	3.7	0.3	0.0	3.7	9.7
		Cov.	1.2	15.7	12.2	1.5	5.2	9.3
		Total	1.6	19.4	12.5	1.5	8.9	19.0
99214	Office or other outpatient visit	Med.	0.2	4.4	0.3	0.3	3.8	8.2
		Cov.	0.5	14.6	16.0	3.3	5.3	15.3
		Total	0.7	19.1	16.2	3.6	9.2	23.5
99215	Office or other outpatient visit	Med.	0.1	6.3	1.0	0.0	5.6	6.2
		Cov.	1.0	19.1	28.4	5.6	7.1	19.6
		Total	1.1	25.4	29.4	5.6	12.6	25.8
	Hospital inpatient services							
99222	Initial hospital care, per day	Med.	0.6	11.3	1.5	3.1	9.8	2.5
		Cov.	0.0	30.6	28.9	3.1	8.7	7.7
		Total	0.6	41.9	30.4	6.3	18.5	10.2

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Code	Description	Type[a]	N. Calif.	S. Calif	N.C.	S.C.	Ill.	Wis.
99223	Initial hospital care, per day	Med.	0.3	9.4	2.6	1.2	7.8	6.6
		Cov.	0.3	17.9	24.2	0.0	6.9	7.9
		Total	0.5	27.4	26.8	1.2	14.7	14.5
99231	Subsequent hospital care, per day	Med.	0.3	12.4	0.3	2.2	13.4	21.5
		Cov.	0.1	16.8	22.4	1.1	6.2	9.5
		Total	0.4	29.3	22.8	3.3	19.6	31.0
99232	Subsequent hospital care, per day	Med.	0.9	13.7	0.4	1.7	11.9	17.1
		Cov.	0.2	11.4	16.7	1.6	5.2	8.7
		Total	1.1	25.1	17.1	3.3	17.1	25.7
99233	Subsequent hospital care, per day	Med.	0.8	22.9	0.3	2.1	9.1	20.4
		Cov.	0.1	13.8	26.4	1.6	6.5	13.7
		Total	0.9	36.7	26.7	3.7	15.6	34.1
99238	Hospital discharge day management	Med.	0.5	12.2	0.4	0.3	10.3	13.7
		Cov.	0.1	15.6	17.2	0.6	6.2	6.2
		Total	0.6	27.8	17.6	0.9	16.6	19.9
	Consultations							
99243	Office consultation, new or established patient	Med.	0.0	3.2	0.6	0.0	0.0	6.8
		Cov.	0.6	18.1	57.4	1.4	0.4	13.6
		Total	0.6	21.4	57.9	1.4	0.4	20.4
99244	Office consultation, new or established patient	Med.	0.0	3.0	0.0	0.0	0.0	3.6
		Cov.	0.7	12.9	65.6	2.1	1.0	10.9
		Total	0.7	15.9	65.6	2.1	1.0	14.5
99245	Office consultation, new or established patient	Med.	0.0	2.4	0.0	0.0	0.0	12.8
		Cov.	1.4	10.3	53.8	0.0	1.0	11.2
		Total	1.4	12.7	53.8	0.0	1.0	24.1
99253	Initial inpatient consultation, new or established patient	Med.	0.5	2.6	2.2	0.0	0.0	1.1
		Cov.	0.0	15.3	61.3	0.0	4.1	15.5
		Total	0.5	17.9	63.5	0.0	4.1	16.6
99254	Initial inpatient consultation, new or established patient	Med.	0.2	2.3	0.4	0.8	0.0	0.5
		Cov.	0.4	15.2	61.7	0.0	2.2	18.1
		Total	0.6	17.5	62.1	0.8	2.2	18.6
99255	Initial inpatient consultation, new or established patient	Med.	0.4	2.6	0.0	0.0	0.0	0.0
		Cov.	0.0	10.3	59.2	1.3	4.2	9.3
		Total	0.4	12.9	59.2	1.3	4.2	9.3

APPENDIX II

Code	Description	Type[a]	N. Calif.	S. Calif	N.C.	S.C.	Ill.	Wis.
99262	Follow-up inpatient consultation for an established patient	Med.	0.0	10.5	1.6	0.0	0.0	33.0
		Cov.	0.0	14.6	79.7	8.6	5.3	26.2
		Total	0.0	25.1	81.3	8.6	5.3	59.3
	Emergency department services							
99283	Emergency department visit	Med.	0.1	12.5	1.0	0.8	0.0	14.7
		Cov.	0.0	4.3	16.3	2.9	3.9	8.1
		Total	0.1	16.8	17.2	3.7	3.9	22.8
99284	Emergency department visit	Med.	0.2	8.5	1.7	0.0	0.0	4.8
		Cov.	0.0	8.7	10.0	1.2	2.8	15.1
		Total	0.2	17.1	11.7	1.2	2.8	19.9
99285	Emergency department visit	Med.	0.0	30.6	2.9	0.9	0.0	8.3
		Cov.	0.0	7.2	22.9	0.9	2.2	16.0
		Total	0.0	37.8	25.8	1.9	2.2	24.3
	Critical care services							
99291	Critical care, including diagnostic and therapeutic services, first hour	Med.	0.3	6.9	1.8	4.2	13.8	27.7
		Cov.	0.8	6.7	43.2	0.0	30.5	10.0
		Total	1.0	13.6	45.0	4.2	44.3	37.7
	Nursing facility services							
99311	Subsequent nursing facility care, per day	Med.	0.0	2.6	0.8	0.0	4.1	5.0
		Cov.	0.1	9.9	14.2	0.2	1.3	12.8
		Total	0.1	12.6	14.9	0.2	5.3	17.8
99312	Subsequent nursing facility care, per day	Med.	0.2	4.3	0.3	0.0	3.6	3.1
		Cov.	0.1	12.0	17.2	0.0	0.8	11.1
		Total	0.2	16.3	17.5	0.0	4.4	14.2
	HCPCS							
A0010	Ambulance service, basic life support	Med.	0.3	20.4	1.2	48.6	0.0	42.4
		Cov.	0.3	18.9	270.3	5.6	0.8	52.2
		Total	0.6	39.3	271.5	54.2	0.8	94.5
A0020	Ambulance service, (BLS) per mile, transport, one way	Med.	6.2	74.3	1.4	18.4	0.1	49.5
		Cov.	1.6	35.1	459.9	1.0	1.7	49.8
		Total	7.8	109.4	461.2	19.4	1.8	99.4
A0150	Ambulance, nonemergency transport, base rate, one way	Med.	302.5	83.2	1.9	13.0	[illegible]	[illegible]
		Cov.	11.1	38.7	264.9	0.0		
		Total	313.5	122.0	266.8	13.0		

APPENDIX II

Code	Description	Type[a]	N. Calif.	S. Calif	N.C.	S.C.	Ill.	Wis.
A0220	Ambulance service, advanced life support, all-inclusive services	Med.	0.4	10.8	0.0	47.2	0.0	[b]
		Cov.	0.7	17.2	100.8	27.6	0.0	
		Total	1.1	28.1	100.8	74.8	0.0	
A2000	Manipulation of the spine by chiropractor	Med.	77.1	72.2	173.9	116.5	142.8	18.3
		Cov.	0.7	41.1	89.5	77.4	4.5	145.8
		Total	77.8	113.4	263.4	194.0	147.2	164.1
J9217	Leuprolide acetate, for depot suspension, 7.5 mg	Med.	0.0	0.9	17.1	0.0	0.0	2.7
		Cov.	0.0	8.2	21.0	6.8	0.0	2.7
		Total	0.0	9.1	38.1	6.8	0.0	5.4

[a]Categories are Med. = medical necessity denial rate; Cov. = noncovered care denial rate; Total = medical necessity + noncovered care. (The "Total" category may not always be equal to the sum of the "Med." and "Cov." categories because it was independently rounded.)

[b]No allowed services were found for this code.

APPENDIX III
APPENDIX III

1993 DENIAL RATES (PER 1,000 SERVICES ALLOWED) FOR MEDICAL NECESSITY AND NONCOVERED CARE BY CARRIER

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
	Anesthesia							
00142	Anesthesia for procedure on eye, lens surgery	Med.	0.0	1.0	4.5	0.0	1.6	4.8
		Cov.	17.3	5.8	37.9	0.0	0.9	10.6
		Total	17.3	6.8	42.5	0.0	2.5	15.4
00562	Anesthesia, procedure on heart, pericardium and great vessels of chest; oxygenator with pump	Med.	0.0	0.0	13.3	0.0	0.0	0.0
		Cov.	11.6	3.5	17.7	0.0	0.0	0.0
		Total	11.6	3.5	31.0	0.0	0.0	0.0
	Musculoskeletal							
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement, with or without allograft	Med.	0.0	4.0	6.3	0.0	4.8	0.0
		Cov.	0.0	12.0	25.3	0.0	0.0	6.3
		Total	0.0	15.9	31.6	0.0	4.8	6.3
27236	Open treatment of closed or open femoral fracture	Med.	0.0	0.0	0.0	0.0	5.0	0.0
		Cov.	0.0	16.5	40.7	0.0	0.0	36.7
		Total	0.0	16.5	40.7	0.0	5.0	36.7
27244	Open treatment of closed or open intertrochanteric	Med.	0.0	5.2	0.0	0.0	0.0	0.0
		Cov.	0.0	15.6	58.8	0.0	3.8	7.2
		Total	0.0	20.8	58.8	0.0	3.8	7.2
27447	Arthroplasty, knee, condyle, and plateau; medical and lateral compartments, with or without patella resurfacing	Med.	0.0	11.2	3.9	0.0	2.8	0.0
		Cov.	0.0	8.4	85.6	0.0	0.0	11.6
		Total	0.0	19.7	89.5	0.0	2.8	11.6
	Cardiovascular							
33512	Coronary artery bypass, 3 coronary venous grafts	Med.	0.0	0.0	0.0	0.0	11.8	0.0
		Cov.	0.0	8.4	32.3	0.0	0.0	0.0
		Total	0.0	8.4	32.3	0.0	11.8	0.0
33513	Coronary artery bypass, 4 coronary venous grafts	Med.	9.4	0.0	0.0	0.0	11.2	0.0
		Cov.	0.0	0.0	0.0	0.0	0.0	0.0
		Total	9.4	0.0	0.0	0.0	11.2	0.0
36415	Routine venipuncture, collection of specimen	Med.	0.2	9.5	1.8	0.4	0.2	0.0
		Cov.	3.7	5.8	28.3	1.3	5.4	13.0
		Total	3.9	15.3	30.1	1.7	5.5	13.0
	Digestive							

APPENDIX III
APPENDIX III

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
43235	Upper gastrointestinal endoscopy, including esophagus, stomach, duodenum, or jejunum; complex diagnostic	Med.	0.0	0.9	0.0	0.0	0.9	0.0
		Cov.	1.0	6.3	33.5	0.0	1.9	7.7
		Total	1.0	7.2	33.5	0.0	2.8	7.7
43239	Upper gastrointestinal endoscopy, including esophagus, stomach, duodenum, or jejunum; for biopsy or collections by brushing	Med.	0.0	1.3	1.2	0.0	0.0	0.0
		Cov.	5.0	10.4	20.4	8.0	11.0	11.2
		Total	5.0	11.7	21.6	8.0	11.0	11.2
45378	Colonoscopy, fiberoptic, beyond splenic flexure, diagnostic, with or without colon decompression	Med.	0.0	0.8	0.0	0.0	0.0	0.0
		Cov.	0.9	5.0	20.7	2.2	2.7	1.9
		Total	0.9	5.8	20.7	2.2	2.7	1.9
45385	Colonoscopy, fiberoptic, beyond splenic flexure, same as above, with removal of polypoid lesions	Med.	0.0	0.0	0.0	0.0	0.0	0.0
		Cov.	2.2	5.7	27.2	0.0	28.3	4.6
		Total	2.2	5.7	27.2	0.0	28.3	4.6
	Urinary							
52000	Cystourethroscopy (separate procedure)	Med.	1.3	0.0	1.0	0.0	0.0	0.0
		Cov.	0.7	1.5	21.3	0.0	0.0	19.9
		Total	2.0	1.5	22.3	0.0	0.0	19.9
52601	Transuretheral resection of prostate, including control of post-op bleeding, complete	Med.	16.6	14.3	12.1	0.0	0.0	0.0
		Cov.	0.0	0.0	30.3	0.0	0.0	5.9
		Total	16.6	14.3	42.4	0.0	0.0	5.9
	Eye and ocular adenxa							
65855	Trabeculoplasty by laser surgery, one or more sessions	Med.	0.0	0.0	9.0	0.0	0.0	0.0
		Cov.	0.0	36.3	45.0	0.0	0.0	96.5
		Total	0.0	36.3	54.1	0.0	0.0	96.5
66821	Discussion of secondary membranous cataract (opacified posterior)	Med.	0.0	0.6	1.0	0.0	0.0	0.0
		Cov.	3.1	4.0	31.4	0.0	1.2	2.0
		Total	3.1	4.5	32.4	0.0	1.2	2.0
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis	Med.	0.3	1.8	12.9	1.0	0.0	1.5
		Cov.	6.7	7.2	23.5	0.0	2.3	3.1
		Total	6.9	9.1	36.4	1.0	2.3	4.6
	Radiology							
71010	Radiologic exam, chest, single view, frontal	Med.	5.1	17.3	7.0	0.4	57.5	0.1
		Cov.	0.6	12.1	18.6	0.7	0.4	10.4
		Total	5.6	29.4	25.6	1.1	58.0	10.5
71020	Radiologic exam, chest, 2 views, frontal and lateral	Med.	7.6	14.6	1.2	0.2	90.2	0.1
		Cov.	0.3	5.8	24.9	5.0	3.6	13.4
		Total	7.9	20.4	26.1	5.2	93.8	13.5

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Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
76091	Mammography, bilateral	Med.	47.0	63.5	0.0	2.6	0.0	0.0
		Cov.	0.0	16.0	128.5	82.8	0.0	147.3
		Total	47.0	79.5	128.5	85.4	0.0	147.3
77430	Weekly radiation therapy management, complex	Med.	0.0	4.5	0.0	0.0	0.0	0.0
		Cov.	0.0	0.0	61.5	0.0	0.0	4.3
		Total	0.0	4.5	61.5	0.0	0.0	4.3
78465	Myocardial perfusion imaging	Med.	0.0	248.4	6.4	6.0	0.0	0.0
		Cov.	0.0	3.9	10.3	12.0	0.0	0.0
		Total	0.0	252.3	16.7	18.0	0.0	0.0
	Path/lab							
80019	Automated multichannel test, 19 or more clinical chemistry tests	Med.	0.1	1.7	0.5	1.4	138.9	0.0
		Cov.	1.0	7.4	10.1	1.8	0.0	12.6
		Total	1.1	9.0	10.6	3.2	138.9	12.6
84443	Thyroid stimulating hormone (TSH)	Med.	0.1	2.3	0.4	4.0	0.2	0.0
		Cov.	1.0	3.0	7.0	2.7	0.0	11.6
		Total	1.1	5.3	7.4	6.7	0.2	11.6
85025	Blood count, hemogram and platelet count, automated and CBC	Med.	0.1	1.7	0.6	0.9	0.0	0.0
		Cov.	0.4	4.9	8.2	0.5	0.0	8.3
		Total	0.5	6.7	8.8	1.4	0.0	8.3
86316	Immunoassay for tumor antigen (for example, prostate specific antigen)	Med.	0.2	3.8	0.6	1.2	0.4	6.1
		Cov.	1.5	6.1	16.6	0.0	0.0	15.8
		Total	1.7	9.9	17.2	1.2	0.4	21.9
88305	Level IV--surgical pathology, gross and microscopic exam	Med.	0.1	5.7	6.2	1.3	0.6	0.7
		Cov.	0.5	19.0	21.7	0.9	0.0	6.5
		Total	0.6	24.7	27.9	2.2	0.6	7.2
	Medicine							
90843	Individual medical psychotherapy by a physician, approximately 20-30 minutes	Med.	0.2	8.7	5.3	0.0	0.6	0.7
		Cov.	0.2	11.5	16.8	0.7	1.6	38.8
		Total	0.4	20.2	22.1	0.7	2.3	39.5
90844	Individual medical psychotherapy by a physician, approximately 45-50 minutes	Med.	0.0	6.3	2.9	0.0	1.4	1.6
		Cov.	0.1	18.4	23.2	0.0	0.3	178.0
		Total	0.1	24.7	26.1	0.0	1.7	179.6
92004	Opthalmologic services: medical examination and evaluation	Med.	19.2	4.2	1.2	0.0	19.6	108.4
		Cov.	1.2	13.8	65.3	0.8	35.5	9.0
		Total	20.4	18.0	66.5	0.8	55.1	117.4

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Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
92012	Ophthalmologic services: medical exam and evaluation, with initiation or continuation of diagnostic and treatment program	Med.	2.5	2.2	1.5	0.4	9.1	29.7
		Cov.	0.1	3.0	61.3	0.4	21.0	4.6
		Total	2.7	5.2	62.8	0.7	30.0	34.3
92014	Ophthalmologic services: medical exam and evaluation, with initiation or continuation of diagnostic and treatment program	Med.	7.0	1.4	0.6	0.0	13.8	80.1
		Cov.	1.3	6.6	56.6	0.3	24.2	7.0
		Total	8.3	8.0	57.3	0.3	38.0	87.1
92982	Percutaneous transluminal coronary balloon angioplasty, single vessel	Med.	46.3	100.3	125.0	0.0	12.7	0.0
		Cov.	78.4	3.5	125.0	54.9	237.3	0.0
		Total	124.8	103.8	250.0	54.9	250.0	0.0
93005	Electrocardiogram, routine, with at least 12 leads; tracing only, without interpretation and report	Med.	0.3	18.6	1.5	0.2	0.1	1.2
		Cov.	12.1	11.5	87.7	2.3	28.8	18.4
		Total	12.4	30.1	89.2	2.5	28.9	19.6
93307	Echocardiography, real-time with image documentation (2D), with or without M-mode recording, complete	Med.	1.7	173.3	1.1	4.4	0.0	0.0
		Cov.	0.5	25.1	36.3	0.0	0.0	3.1
		Total	2.2	198.5	37.3	4.4	0.0	3.1
93320	Doppler echocardiography, pulsed wave or continuous wave with spectral display, complete	Med.	0.0	129.1	3.3	4.3	0.0	4.9
		Cov.	0.6	22.3	26.9	0.0	0.0	4.4
		Total	0.6	151.4	30.3	4.3	0.0	9.3
93547	Combined left heart catheterization, selective coronary angiography, 1 or more coronary arteries, and selective left ventricular angiography	Med.	1.3	3.1	0.0	0.0	0.0	0.0
		Cov.	2.6	56.3	10.0	0.0	47.0	3.9
		Total	3.9	59.5	10.0	0.0	47.0	3.9
93549	Combined right and left heart catheterization, selective coronary angiography, 1 or more coronary arteries	Med.	3.8	3.9	180.6	0.0	0.0	0.0
		Cov.	5.7	46.7	12.9	0.0	63.9	3.5
		Total	9.5	50.6	193.5	0.0	63.9	3.5
93880	Duplex scan of extracranial arteries, complete bilateral study	Med.	0.0	209.9	1.2	0.0	0.0	0.0
		Cov.	0.4	13.2	29.9	31.4	0.0	7.7
		Total	0.4	223.1	31.1	31.4	0.0	7.7
	Office or other outpatient services							
99202	Office or other outpatient visit for the evaluation	Med.	0.3	23.9	0.8	0.5	2.7	0.4
		Cov.	21.5	6.5	58.5	18.9	26.3	107.7
		Total	21.8	30.4	59.3	19.4	28.9	108.0
99203	Office or other outpatient visit	Med.	0.1	14.7	0.7	0.0	4.5	0.0
		Cov.	11.9	8.0	85.3	12.2	29.2	109.7
		Total	12.1	22.7	86.0	12.2	33.8	109.7
99204	Office or other outpatient visit	Med.	0.2	7.2	1.3	0.0	1.9	0.0
		Cov.	4.0	5.9	55.4	7.4	22.6	65.5
		Total	4.2	13.1	56.7	7.4	24.5	65.5

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Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
99205	Office or other outpatient visit	Med.	0.0	5.7	1.5	0.0	4.5	0.0
		Cov.	3.4	13.9	63.4	2.6	45.6	66.8
		Total	3.4	19.7	64.8	2.6	50.2	66.8
99211	Office or other outpatient visit	Med.	0.6	36.6	0.2	0.0	7.2	12.0
		Cov.	27.7	4.9	52.3	13.8	22.0	55.6
		Total	28.3	41.6	52.6	13.8	29.2	67.6
99212	Office or other outpatient visit	Med.	0.7	15.7	0.7	0.0	6.2	6.9
		Cov.	4.1	6.2	46.7	7.0	2.2	27.6
		Total	4.8	21.8	47.4	7.1	8.4	34.5
99213	Office or other outpatient visit	Med.	0.3	5.6	0.5	0.0	4.4	3.0
		Cov.	1.5	4.5	26.9	1.0	1.8	17.3
		Total	1.8	10.2	27.5	1.0	6.2	20.3
99214	Office or other outpatient visit	Med.	0.3	5.2	0.3	0.0	3.7	2.0
		Cov.	0.8	4.4	38.1	2.0	3.0	24.9
		Total	1.1	9.6	38.5	2.0	6.7	27.0
99215	Office or other outpatient visit	Med.	0.0	6.0	1.0	0.0	3.6	1.8
		Cov.	1.6	5.9	43.1	4.8	7.5	33.4
		Total	1.6	11.9	44.0	4.8	11.1	35.3
	Hospital inpatient services							
99222	Initial hospital care, per day	Med.	0.4	8.7	2.8	2.6	16.9	0.7
		Cov.	0.2	18.2	73.0	0.5	2.4	3.3
		Total	0.6	26.9	75.8	3.1	19.3	4.0
99223	Initial hospital care, per day	Med.	0.8	7.2	2.6	2.8	12.2	3.6
		Cov.	0.3	16.4	64.8	0.0	4.2	4.0
		Total	1.1	23.6	67.4	2.8	16.5	7.6
99231	Subsequent hospital care, per day	Med.	7.7	20.7	5.8	3.2	17.6	10.1
		Cov.	0.4	11.8	35.2	0.0	6.1	8.8
		Total	8.1	32.5	41.0	3.2	23.7	18.9
99232	Subsequent hospital care, per day	Med.	8.7	20.8	4.7	4.1	17.8	9.8
		Cov.	0.3	10.6	39.5	0.0	4.5	11.6
		Total	9.0	31.3	44.2	4.1	22.3	21.4
99233	Subsequent hospital care, per day	Med.	11.4	24.8	4.1	5.7	17.1	12.0
		Cov.	0.1	7.4	53.6	1.4	7.0	17.8
		Total	11.4	32.2	57.7	7.1	24.2	29.8
99238	Hospital discharge day management	Med.	0.1	34.1	2.1	0.3	15.4	7.2
		Cov.	0.6	12.8	41.9	0.5	6.6	9.3
		Total	0.8	46.9	44.0	0.8	22.0	16.5

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Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
	Consultations							
99243	Office consultation, new or established patient	Med.	0.5	0.9	1.5	0.0	0.0	5.2
		Cov.	0.3	16.6	175.4	1.3	1.2	5.7
		Total	0.8	17.6	176.8	1.3	1.2	11.0
99244	Office consultation, new or established patient	Med.	0.3	2.2	0.9	0.0	0.0	1.1
		Cov.	0.3	16.9	143.9	0.0	1.9	9.1
		Total	0.6	19.1	144.7	0.0	1.9	10.3
99245	Office consultation, new or established patient	Med.	0.4	3.5	0.0	0.0	0.0	0.0
		Cov.	0.0	18.8	173.4	0.0	2.5	3.4
		Total	0.4	22.4	173.4	0.0	2.5	3.4
99253	Initial inpatient consultation, new or established patient	Med.	0.0	3.8	2.2	1.1	0.0	2.5
		Cov.	0.0	36.0	120.8	0.0	0.8	6.0
		Total	0.0	39.8	123.0	1.1	0.8	8.6
99254	Initial inpatient consultation, new or established patient	Med.	0.8	3.2	2.2	0.0	0.0	1.9
		Cov.	0.2	14.5	87.6	0.0	2.6	6.9
		Total	1.0	17.7	89.8	0.0	2.6	8.8
99255	Initial inpatient consultation, new or established patient	Med.	0.0	2.5	0.0	0.0	0.0	4.4
		Cov.	0.6	14.4	120.7	0.0	3.7	7.6
		Total	0.6	16.8	120.7	0.0	3.7	12.0
99262	Follow-up inpatient consultation for an established patient	Med.	0.0	33.3	1.9	0.0	0.0	4.5
		Cov.	0.7	10.9	198.1	0.0	9.6	23.8
		Total	0.7	44.2	200.0	0.0	9.6	28.3
	Emergency department services							
99283	Emergency department visit	Med.	0.3	17.1	6.0	0.0	0.0	1.1
		Cov.	0.0	5.4	20.3	0.0	3.4	4.9
		Total	0.3	22.6	26.3	0.0	3.4	6.0
99284	Emergency department visit	Med.	0.0	14.0	1.9	0.5	0.0	3.1
		Cov.	0.1	8.4	16.9	0.0	1.4	6.4
		Total	0.1	22.4	18.8	0.5	1.4	9.5
99285	Emergency department visit	Med.	0.0	79.6	2.1	0.7	0.0	4.5
		Cov.	0.0	9.8	33.4	0.7	1.5	7.2
		Total	0.0	89.4	35.5	1.4	1.5	11.7
	Critical care services							
99291	Critical care, including diagnostic and therapeutic services, first hour	Med.	12.0	6.7	3.9	1.8	12.9	12.5
		Cov.	0.7	6.7	164.2	0.0	15.0	60.4
		Total	12.7	13.5	168.1	1.8	27.9	72.8

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Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
	Nursing facility services							
99311	Subsequent nursing facility care, per day	Med.	0.0	3.8	0.5	0.0	6.8	1.3
		Cov.	0.1	18.8	22.8	0.2	0.5	8.0
		Total	0.1	22.6	23.3	0.2	7.2	9.2
99312	Subsequent nursing facility care, per day	Med.	0.1	4.2	2.0	0.0	4.2	1.6
		Cov.	0.1	20.2	18.8	0.7	1.4	5.8
		Total	0.1	24.4	20.8	0.7	5.6	7.4
	HCPCS							
A0010	Ambulance service, basic life support	Med.	1.4	13.7	114.0	0.8	0.0	31.1
		Cov.	0.0	21.6	299.1	0.8	2.2	90.8
		Total	1.4	35.3	413.2	1.5	2.2	121.9
A0020	Ambulance service, (BLS) per mile, transport, one way	Med.	3.1	64.3	98.0	0.0	0.0	38.4
		Cov.	0.0	79.5	664.6	0.0	1.9	92.0
		Total	3.1	143.7	762.6	0.0	1.9	130.4
A0150	Ambulance, nonemergency transport, base rate, one way	Med.	169.5	81.2	59.2	0.8	[b]	[b]
		Cov.	0.3	72.5	311.8	0.0	[b]	[b]
		Total	169.8	153.7	371.1	0.8		
A0220	Ambulance service, advanced life support, all-inclusive services	Med.	0.0	15.3	29.7	0.0	0.0	[b]
		Cov.	0.0	23.9	83.2	0.0	0.3	[b]
		Total	0.0	39.2	112.9	0.0	0.3	
A2000	Manipulation of the spine by chiropractor	Med.	145.0	66.2	236.5	0.0	133.8	94.0
		Cov.	0.9	67.6	106.3	14.0	12.5	111.9
		Total	145.9	133.8	342.8	14.0	146.2	205.9
J9217	Leuprolide acetate, for depot suspension, 7. 5 mg	Med.	0.8	0.0	21.1	0.0	0.0	11.9
		Cov.	0.8	7.3	7.0	0.0	0.0	5.9
		Total	1.5	7.3	28.2	0.0	0.0	17.8

[a]Categories are Med. = medical necessity denial rate; Cov. = noncovered care denial rate; Total = medical necessity + noncovered care. (The "Total" category may not always be equal to the sum of the "Med." and "Cov." categories because it was independently rounded.)

[b]No allowed services were found for this code.

CARRIER REPORTING OF SERVICE DENIALS

A carrier might not pay for a particular service for numerous reasons. And, because carriers must explain denials in writing to providers and beneficiaries, carriers must track the specific reason for a denial when processing a claim. This is accomplished by assigning a unique "action code" to each billed service on a claim. For example, code "AB" might indicate that the carrier denied a B-12 injection because the diagnostic code listed on the claim was, based on HCFA coverage parameters, not medically necessary. Similarly, "BB" might indicate that an office visit was denied because the claimant was ineligible for Medicare. While the reasons for denials are generally comparable across all carriers, the "action codes" that carriers use to record the reasons are not; hence, the code "AB" might not be used by all carriers or, if used, might mean something different for each.

Before transmitting information to the National Claims History (NCH) File, HCFA's central database for claims, HCFA requires that each carrier translate its set of action codes into 10 broad denial categories (see table I.2).[30] HCFA does not instruct carriers in how to make this classification. Thus, "AB" might be translated for NCH as "C" (for noncovered service) and "BB" as "O" (other denial). However, given that carriers have different sets of action codes to classify, the question naturally arises: Is the resulting NCH classification comparable across carriers? In other words, Does "noncovered service" or "medically unnecessary" mean the same thing to different carriers?

To answer this question, we made use of the fact that carrier action codes are connected to HCFA denial messages (a common set of messages that carriers are required to use in their written communications with beneficiaries). That is, while North Carolina and Wisconsin may use different internal action codes to record the reason for denying a service, they use the same set of HCFA messages to describe that reason to the beneficiary. By comparing the HCFA messages, rather than action codes, with NCH categories, it is possible to gain a sense of how similar different carriers' coding practices are. For illustrative purposes, table IV.1 displays a sample of carrier action codes, HCFA denial messages, and NCH categories for two carriers.[31]

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[30]Before data reach NCH, they are compiled in an intermediate database called the Common Working File (CWF). The CWF is a repository for Medicare claims that carriers use to check patient history and verify claimant eligibility.

[31]HCFA issues over 300 different standard messages that carriers are required to use when communicating with beneficiaries. Carriers are free to "pick and choose" from this universe messages that best suit

APPENDIX IV

Table IV.1: Sample Translation Table for Two Carriers

Carrier action code	HCFA message number	NCH reason category
North Carolina		
AA	1.01	Noncovered care
II	14.13	Noncovered care
IJ	15.01	Medical necessity
IH	9.44	Noncovered care
VI	10.05	Noncovered care
Wisconsin		
30	1.01	Noncovered care
I1	14.13	Noncovered care
AR	15.01	Medical necessity
Not applicable	Not used	Not applicable
18	10.05	Medical necessity

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the needs of their jurisdictions.

Table IV.1 shows that when North Carolina uses "AA" and Wisconsin "30," both carriers send the beneficiary the same message: "Medicare pays for transportation to the closest hospital or skilled nursing facility that can provide the necessary care" (HCFA message 1.01). Similarly, when they transmit this information to NCH, both carriers report the denial as relating to "noncovered care." However, when North Carolina and Wisconsin send the beneficiary the message, "HCFA does not pay for routine foot care" (HCFA message 10.05), they report different reasons for denial to NCH. North Carolina reports this as a "noncovered" care denial while Wisconsin considers it a "medical necessity" denial. Reporting consistency among carriers varies by type of message. For example, table IV.1 shows that there is agreement for three actions and disagreement for one action and, in a third instance, one of the carriers uses a particular HCFA message that the other does not.

We collected translation tables, similar to table IV.1, for all six carriers in this study and compared HCFA message numbers with corresponding NCH categories. We restricted our comparison of HCFA messages to those that were (1) used for communicating denials, (2) used by at least three carriers, and (3) classified as a "medical necessity" denial by at least one carrier. Table IV.2 shows how carriers report the service denial reason to NCH when a particular HCFA message is sent to a beneficiary. Table IV.3 displays the actual messages that correspond to the HCFA message numbers. As table IV.2 demonstrates, carriers generally agree on how they classify HCFA messages for reporting purposes; instances of carrier disagreement center primarily on the distinction between "medically unnecessary" and "noncovered care" and, to a lesser extent, on "other." For messages that HCFA has explicitly designated as pertaining to "medical necessity" (messages 15.01 through 15.33), we found the highest level of carrier agreement.

Table IV.2: CWF Categories by HCFA Message Number and Carrier[a]

HCFA message number	Northern California	Southern California	North Carolina	South Carolina	Illinois	Wisconsin
1.01	N	C	C	C	C	C
1.03	O	C		C		N
1.05	N	C		C		C
1.10		N/O	N	N		N
1.11	N	N		N		N
1.12	N	N		N		C
3.01	N	N				C/N
3.02	N	C	C			C
3.03	N	C	N	C		N
3.04	N	C	N	C		O
4.01	O	C	C	C		N
4.02	C	O		C		C/N
4.04	N	C	C	C		
4.05	N	C	C	C		
4.06	N	C	C	C		
4.07	N	O	O	C	C	C
4.08	N	O	O	C	C	C/M
4.18	N	O	C	O	C	C
6.02		N	N	C		C
6.04	N	C	C			
9.01	O	O	C		C	C/I/N/O/S
9.16	N	O	C	O	C/O	O
9.18		N	O		C	
10.05	C		C	C		N
11.04	N	C	O		S	C/I/O
14.02	N	C	C	C		C
14.04	N	C		C		15.01
15.01	N	N	N	N	N/O	N
15.07	N	N	N	N	C/N	I/N
15.09	N	N	N	N	C/N	C/N
15.10	N	N		N		

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HCFA message number	Northern California	Southern California	North Carolina	South Carolina	Illinois	Wisconsin
15.11	N	N	N	N	N	C/N
15.12	N	N		N	C/N/O	N
15.13	N	N	N	N	N	C/N
15.14	N	N	N	N	C/N/O	C/N
15.15	N	N		N	N	
15.16	N	N/O	N	N		
15.17	N	N		N		N
15.18	N	N	N	N	N	
15.19		N	N	N		
15.21	N	N	N	N	C	
15.22	N				N/O	C
15.26	N		C	C		N
15.32	N	N	N	C		C
15.33	N	N	N	C		C
16.04	N	I	C	O	C/O	C
16.05	N	C	C	O		C/N
16.07	N	O	C	C	O	C
16.14	N	C/O	C/O	C	C/O	C
16.16	C	O	O	O	C/N/O	C
16.17	N	C	C		C/N	C
16.18	N	O	C	C	C	C
16.19	N	C		N	N	N
16.20	N	C	C	C		C
16.21	N	C	C	C	C	C
16.25	N		C	C		C
16.74	C	N	C	O		C
16.75	C	N	C	O	C	C
16.76	N	N	C	O	C	C
16.77	N	N	C	O		C
16.78	C	N	C	O	C	C/L
16.79		N	C	O	C/O	C/L
17.01	C	C	C	C		N
17.36		N	C	O		
18.01	C	C	C	C	C/N/O	C/N

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HCFA message number	Northern California	Southern California	North Carolina	South Carolina	Illinois	Wisconsin
18.03	N	C	C	C		C
18.05	N	O	C	C		C
18.06	N	O	C/O	C	C	C
18.07	N	O	O	C		
18.08	N	O	O	C	C/O	C
18.12	N		N			C
19.01	C	O	C	O		C/N
19.05	C	N	C	O	C	C
19.06	C	N	C	O		C
21.09	C	C/N/O	C	C	C/N/O	C
23.04		N/O	C	O	O	C/N
23.05	C	C	C		N	C
23.10		N/O	C	N		
23.14	N				C	C
26.01	C	C/O	C	C	C	C/N
26.04	N	C	C	C		N
26.05	N	C	O	C	C	N
26.06	N	C	C	C		C
29.11	N	C	O	S	S	C
33.02	N		O			C

[a]CWF categories are C = noncovered service; I = invalid care; L = Clinical Laboratory Improvement Act (that is, unapproved lab); N = medically unnecessary; O = other; P = physician ownership denial; S = secondary payer; X = Medicare secondary payer cost avoided; Y = IRS/SSA data match. Empty cells indicate that the carrier does not use that message.

Table IV.3: HCFA Messages for Denied Services

HCFA message number[a]	Narrative
1.01	Medicare pays for transportation to the closest hospital or skilled nursing facility that can provide the necessary care.
1.03	Medicare does not pay for separate charges by the mile.
1.05	Medicare does not pay for transportation in a wheelchair van.
1.10	The information we have in your case does not support the need for this ambulance service.
1.11	The information we have in your case does not support the need for this transportation. (NOTE: Use of transportation between places of medical care.)
1.12	The information we have in your case does not support the need for extra help in the ambulance.
3.01	Medicare pays for the services of a chiropractor only when "recent" x-rays support the need for the services. "Recent" means the x-rays were taken within the past 12 months.
3.02	Medicare pays for chiropractic services only to correct a subluxation of the spine.
3.03	Medicare does not pay for this because your x-ray does not support the need for the service.
3.04	Medicare does not pay for this because the x-ray was not taken near enough to the time treatment began.
4.01	Medicare does not pay for this because it is part of the total charge at the place of treatment.
4.02	Medicare does not pay for this because it is part of the monthly charge for dialysis.
4.04	Medicare does not pay for immunosuppressive drugs that are not approved by the Food and Drug Administration.
4.05	Medicare pays for this service up to 1 year after transplant and release from the hospital.
4.06	Each prescription for immunosuppressive drugs is limited to a 30-day nonrefillable supply.
4.07	Medicare can pay for this supply or equipment only if your supplier agrees to accept assignment.
4.08	Medicare can pay only one supplier each month for these supplies and equipment.
4.18	Medicare cannot pay more than $ --- each month for these supplies. (NOTE: The limits for 1992 are $1,600 and $2,080 for CCPD. Update these figures when limits change.)
6.02	Medicare does not pay for drugs that have not been approved by the Food and Drug Administration.
6.04	Medicare pays for this drug only when Medicare pays for the transplant.
9.01	Medicare cannot pay for this because we have not received the information we requested. (NOTE: If assigned claim, add: "The assignment agreement remains in effect and will apply to the new claim.")
9.16	Medicare cannot pay for this because your provider used an invalid or incorrect procedure code and/or modifier for the service you received. Please ask your provider to resubmit the claim with the valid procedure code and/or modifier.
9.18	No certification of medical necessity was received for this equipment.

HCFA message number[a]	Narrative
10.05	Medicare does not pay for routine foot care.
11.04	Another agency handles the bills for these services. We have sent the information to them. They will send you a notice. (Applies to RRB, United Mine Workers.)
14.02	Medicare does not pay for this because the laboratory is not approved for this type of test.
14.04	Medicare does not pay for laboratory procedures which have not been approved by the Food and Drug Administration.
15.01	The information we have in your case does not support the need for this many visits or treatments.
15.07	The information we have in your case does not support the need for this equipment.
15.09	The information we have in your case does not support the need for this service. (If the claim was reviewed by your Medical Staff, add: Your claim was reviewed by our Medical Staff.)
15.10	The information we have in your case does not support the need for this number of home visits per month.
15.11	The information we have in your case does not support the need for this injection.
15.12	The information we have in your case does not support the need for this many injections.
15.13	The information we have in your case does not support the need for similar services by more than one doctor during the same time period.
15.14	The information we have in your case does not support the need for this many services within this period of time.
15.15	The information we have in your case does not support the need for more than one visit a day.
15.16	The information we have in your case does not support the need for the level of service shown on the claim.
15.17	The information we have in your case does not support the need for similar services by more than one doctor of the same specialty.
15.18	The information we have in your case does not support the need for this laboratory test.
15.19	The information we have in your case does not support the need for the level of service shown on this claim. We have approved this service at a reduced level.
15.21	The information we have in your case does not support the need for this foot care.
15.22	The information we have in your case does not support the need for more than one screening PAP smear in three years.
15.26	Medicare does not pay for a surgical assistant for this kind of surgery. The doctor should not bill you for this service.
15.32	Medicare does not pay for two surgeons for this procedure.
15.33	Medicare does not pay for team surgeons for this procedure.
16.04	Medicare does not pay for this in the place or facility where you received it.
16.05	Medicare does not pay for this because the claim does not show that it was prescribed by your doctor.
16.07	Medicare cannot pay for this service because the claim did not show that the Peer Review Organization approved it.

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HCFA message number[a]	Narrative
16.14	Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.
16.16	Medicare does not pay for this service because it is part of another service that was performed at the same time.
16.17	Medicare does not pay for this item or service.
16.18	Medicare does not allow a separate charge for this because it is included as part of the primary service. The provider cannot bill you for this.
16.19	Medicare does not pay for this because it is a treatment that has yet to be proved effective.
16.20	Medicare does not pay for these services or supplies.
16.21	Medicare does not pay for drugs you can give yourself.
16.25	Medicare does not pay for discussions on the telephone with the doctor.
16.74	Medicare does not pay separately for a hospital admission and a visit or consultation on the same day. You should not be billed separately for this service. You do not have to pay this amount. (NOTE: Assigned claim.)
16.75	Medicare does not pay separately for a hospital admission and a visit or consultation on the same day. You do not have to pay this amount. (NOTE: Unassigned claim.)
16.76	Medicare will pay for only the nursing facility service when performed on the same day as another visit in a different site. You should not be billed separately for this service. You do not have to pay this amount. (NOTE: Assigned claim.)
16.77	Medicare will pay for only the nursing facility service when performed on the same day as another visit in a different site. You do not have to pay this amount. (NOTE: Unassigned claim.)
16.78	Medicare does not pay separately for this service. You should not be billed separately for this service. You do not have to pay this amount. (NOTE: Use for global denials for assigned claims.)
16.79	Medicare does not pay separately for this service. You do not have to pay this amount. (NOTE: Use for global denials for unassigned claims.)
17.01	Medicare does not pay for services performed by a private duty nurse.
17.36	Medicare cannot pay for this service as billed. (NOTE: Use when nonphysician practitioners do not separate professional and technical services on the claim.)
18.01	Medicare does not pay for routine examinations and related services.
18.03	Medicare does not pay for this screening examination for women under 35 years of age.
18.05	The place where you had this examination is not approved by Medicare.
18.06	Medicare does not pay for this examination because less than one year (two/three years) has (have) passed since your last examination of this kind.
18.07	Medicare will pay for this screening examination again in one year (two/three years).
18.08	Medicare pays for this examination only once for women age 35-39.
18.12	Medicare pays for screening pap smears only once every three years unless high risk factors are present.
19.01	Medicare does not pay for services of a hospital specialist unless there is an agreement between the hospital and the specialist on how to charge for the services.

HCFA message number[a]	Narrative
19.05	Medicare will pay for only one hospital visit or consultation per physician per day. You do not have to pay this amount.
19.06	Medicare will pay for one hospital visit per day. You do not have to pay this amount.
21.09	Medicare does not pay for this service when performed, referred or ordered by this provider of care.
23.04	Medicare does not pay for these charges because the cost of the care before and after surgery is part of the approved amount for the surgery. (NOTE: Use for global denials.)
23.05	Medicare does not pay for cosmetic surgery and related services.
23.10	Medicare does not pay for a surgical assistant for this kind of surgery.
23.14	Medicare does not pay a doctor for assisting at this kind of surgery. The doctor cannot bill you for this service.
26.01	Medicare does not pay for routine eye examinations or eye refractions.
26.04	Medicare does not pay for eyeglasses or contact lenses except after cataract surgery or if the natural lens of your eye is missing.
26.05	Medicare pays for only one pair of glasses after cataract surgery with lens insertion.
26.06	Medicare does not pay the extra charge for deluxe frames.
33.02	Medicare does not pay for this service when it is performed in an ambulatory surgical center.

[a]For presentation in this table, HCFA message numbers with one decimal place were modified. For example, message 1.1 was changed to 1.01, message 1.3 to 1.03, and so on.

APPENDIX V

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BEFORE THE

COMMITTEE ON SMALL BUSINESS

SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES

AND TECHNOLOGY

UNITED STATES HOUSE OF REPRESENTATIVES

DECEMBER 19, 1994

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss Medicare and its procedures to process, monitor and pay for beneficiary services. I would like to emphasize that Medicare is committed to running an equitable program that pays for medically necessary services for beneficiaries in a fashion that is as consistent as possible. We also realize that improvements need to be made and are taking steps to improve consistency within the Medicare claims processing system, while recognizing that, in a nation-wide program, sources of local variation will remain.

Background

Let me take a moment and discuss some basic facts about the Medicare program. In 1994, Medicare served over 36 million beneficiaries in both parts of its health insurance program. Medicare contracts with over 65 contractors to process beneficiary claims. In FY 1993, Medicare processed over 700 million claims and paid over $143 billion for medical services, treatment and equipment. The Medicare program consists of two distinct parts. Part A covers services furnished by hospitals, home health agencies, skilled nursing facilities, and hospices. Part B is voluntary and is offered to all Medicare Part A beneficiaries for a monthly premium, now $41.10. Part B covers a wide range of medical services and supplies including physician services, outpatient hospital services and home health services not covered under Part A, in addition to diagnostic laboratory tests, x-rays, and the purchase or rental of durable medical equipment.

Medicare contracts with 34 carriers to process Part B claims. In FY 1993, the carriers processed 579.2 million claims, which resulted in $52 billion in payments to physicians and all other Part B providers, which include medical suppliers and equipment. Among their other duties, carriers determine which claims to pay. Each carrier conducts pre-payment and post-payment review of a sample of claims to help insure only appropriate claims are being paid. The sample is based on systematic analysis of utilization data to detect possible areas of fraud and abuse.

In conducting their activities, contractors are expected to follow national policies expressed in statute, regulations, and manual issuances concerning whether services are reasonable and necessary. While governed by these directives, carriers are also expected to exercise discretion in areas not specifically addressed through national policy. Thus, in determining which items and services are covered, carriers are bound by national coverage decisions issued by HCFA where these exist. These decisions largely relate to situations in which a clear, national consensus on treatment has been achieved, but that does not characterize all of medical practice, particularly in an era when technological change is very rapid. Formal national coverage policies encompass only a relatively small part of the coverage decisions carriers must make every day. Therefore, we strongly encourage carriers to work together and with the medical community to create policies that are as consistent as possible while taking into account local medical practice differences.

In circumstances where a reasonable degree of national consensus has not emerged, carriers should work with each other and HCFA to establish consistent standards, while assuring that carriers have the flexibility to allow for reasonable local variation. HCFA's goal is for carriers to make clear coverage decisions based on those criteria to serve Medicare beneficiaries in a timely and effective manner. HCFA requires that local policies be developed in consultation with the local medical community, through the state carrier advisory committee (CAC). This board consists of physicians, representatives of state medical and osteopathic societies, specialists, clinical specialties and can include representatives from the state hospital association, the Peer Review Organization (PRO), or the state Medicaid agency. This committee is utilized to insure the input of physicians practicing in the area.

Similarly, local medical review policy is guided by national policy, but carriers are also expected to be energetic in implementing those local medical review policies that will best protect the integrity of the program. Our Focused Medical Review initiative allows carriers to focus on the problems that are specific to their areas. Focused Medical Review provides carriers the flexibility to target their efforts on particular items or services unique to their region that they identify as potentially overutilized or otherwise problematic. These policies are applied to selected claims through prepayment screens in the claim payment process, certificates of medical necessity, and documentation requirements, among other steps. The policies reflect local medical practice and react to evolving, localized patterns of activity, including

possibly abusive or fraudulent activity, by certain providers and suppliers.

One result is that while claims denial rates for particular services may vary from area to area, this may simply reflect billing patterns and not necessarily be indicative of the differences in the level of services we ultimately pay for. Let me give you a few examples. For cataract extractions (code # 66984), our Southern California carrier denied 10.8 claims per 1,000 services, while in Illinois, the denial rate was 1.1 per 1,000 services. However, these numbers do not mean that beneficiaries are receiving significantly different levels of medical services: for cataract extractions, allowed services per 1,000 enrollees were 24.9 in Southern California and 24.6 in Illinois. Another example relates to the use of chemotherapy for prostate cancer (code # J9217). The North Carolina carrier had a denial rate of 17.1 claims per 1,000 services, while the Wisconsin carrier had a denial rate of 2.7 claims per 1,000 services. The allowed services rates per 1,000 enrollees, however, were very similar: 5.9 for North Carolina and 5.1 for Wisconsin. The last example, I'd like to share with you regards echocardiographic monitoring. Denial rates among the six carriers ranged from a high of 88.8 claims per 1,000 services to a low of 0 claims per 1,000 services. The allowed services rate, on the other hand, ranged from 28.5 per 1,000 enrollees to 34.9 per 1,000 enrollees. Again, despite the large difference in denial rates across carriers, utilization of services was very similar.

I will discuss in further detail later in my testimony some possible reasons for these

differences in denial rates, for instance, variations in local medical practices, development of local medical review policies based on local practice patterns, or varying patterns of fraud and abuse. While these factors contribute to the wide variations in denial rates, the underlying similarity in the allowed services rates is what we would expect to see if the system is working correctly and is paying appropriately, in general for the necessary and reasonable services required by our population.

In short, while Medicare is a national program, we must recognize that medical practitioners frequently differ in their opinions of accepted norms of medical practice across the country. In circumstances where a reasonable degree of national consensus has not emerged, we should not impose standards of medical practice from Washington. Rather, we assure that sound local medical policy is established and that carriers can make clear coverage decisions based on those criteria to serve Medicare beneficiaries in a timely and effective manner.

GAO Report

The General Accounting Office, in a report released today, investigated variation in the denial rates of claims submitted to six Medicare carriers. While claim denial rates can be helpful, one must be extremely cautious in drawing inferences from them regarding variation in services. My staff has had the opportunity to examine the report in draft; I would like to discuss some of their findings.

As I have just described, each carrier has unique screens in place to suspend those claims that reflect identified problems in local medical practices and the behavior of suppliers that serve its geographic area. This means that all carriers are not screening for the same codes. For example, echocardiography (code # 93307) exhibited a large disparity in denial rates, due to a couple of factors. One factor is that carriers review claims differently. Three of the carriers, Northern California, Wisconsin, and Minnesota, screened specific providers that had been identified as billing aberrantly. These carriers screened and then reviewed specific codes that were identified as overutilized by specific providers. In comparison, the Southern California carrier screened all claims related to this service, regardless of the provider. When more claims are reviewed, the result is often a higher incidence of denials, as results for Southern California indicate. We also looked at allowed services data for echocardiography and found the rates of allowed services were similar across the six carriers surveyed. The allowed services rates ranged from 38 to 46 per 1,000 enrollees. Therefore, rates of claims approved for this procedure were similar, despite the variation in claim denial rates.

Variation of claim denial rates among carriers can also be caused by differences across carriers in screening for medical necessity. On average, almost 17 percent of denials result from inadequate justification of medical necessity, but carriers differ in how they monitor claims for medical necessity. For example, one of the codes examined by GAO was for chest x-rays (code # 71010). Illinois had a medical

necessity screen in place to see if the diagnosis was appropriate for the service and had a denial rate of 80.6 claims per 1,000 services. Two other carriers did not have any screens in place; the average denial rate for those carriers was 3 claims per 1,000 services. However, the allowed services rate was similar among these three carriers.

More Consistent Policy Across Carriers

Although variation is expected with respect to the review and processing of claims, HCFA is actively promoting consistency in local policy to assure that only legitimate causes for variation exist. We have taken several steps to assure that carriers work with the local medical community through the use of mandated Carrier Advisory Committees (CAC) in each State, as I had mentioned earlier, to develop local medical review policy. An example illustrating the successful use of CACs to develop a local policy that can be adapted nationally was spearheaded by our New York carrier. The GHI of New York developed local medical policy for a patient-activated, hand-held heart monitoring device. However, the carrier became concerned by the substantial increase in reimbursement and by the disparity in claims in its region compared to others. The Medical Director brought his concerns to the attention of other carriers and HCFA. He then worked with HCFA to identify problems with the current policy and developed new codes, payment conditions, and pricing. Changes to the national coding and payment policy were issued in the Federal Register within the year. Payment levels have decreased and utilization of this service has remained constant

since this new national policy was put in place. This process has illustrated the importance of testing review practices on a local level, learning from those experiences and if successful, implement this policy on a national level. We believe that the use of CACs and HCFA's efforts to promote better communication and cooperation among carriers will result in more consistent policy across carriers.

HCFA Actions To Examine Differences and Address Legitimate Problems

While our goal is to make the review and processing of Medicare claims more consistent and standard, we recognize the differences in opinion from the medical community regarding treatment of beneficiaries. However, there are clearly places where differences should be scrutinized and pursued more aggressively in order to assure that beneficiaries are receiving the services and equipment that Medicare does cover and that are medically necessary.

To accomplish this worthy goal, we are currently implementing and developing initiatives to improve the Medicare claims process.

DMERCs

Starting in October 1993, we have gradually transferred the processing and monitoring of durable medical equipment and supplies from 34 Part B carriers to four durable medical regional carriers (DMERCs). Through these four carriers, we hope to achieve greater efficiency in claims processing and greater consistency in the

development and application of coverage policy and medical review. The Statistical Analysis DMERC (or SADMERC) has the added function of conducting statistical analyses of data provided by all four carriers. This arrangement provides a quick and efficient way to detect aberrancies that could not have been easily discovered in the past.

In addition, the four regional carriers are working together with HCFA to develop coverage policies for durable medical equipment that are substantially consistent. The goal of these policies is to pay appropriately for those items that are reasonable and necessary for medical treatment of Medicare beneficiaries in a fashion that is comparable across the country. By reducing the number of carriers, we have reduced the degree of variation in policies across carriers. By providing more consistency in the durable medical equipment medical review policies throughout the nation, we reduce any inequities due to inappropriate variation in policy.

The Medicare Transaction System

The most exciting of our initiatives is the development of the Medicare Transaction System (MTS). The MTS will allow the processing of claims with one standard processing system at a small number of sites instead of the 60 sites we are currently using. Because of the integration and consolidation of all Medicare claims processing under the MTS, HCFA's capability for electronic analysis of claims will improve significantly. The MTS will allow us to capture national data and make it

readily accessible. For example, MTS will house all contractor edits including local medical review screens. This information will aid in our analysis of utilization and provide useful information for carriers. The MTS will also provide greater capacity to understand individual provider service patterns and the types of services being provided, as well as the potential to identify fraud and abuse in the course of processing claims. Therefore, MTS will improve services to beneficiaries and providers alike, increase HCFA's administrative efficiency, and help in the management of Medicare program expenditures.

We believe that the MTS will also improve the efficacy of post-payment analysis of claims to identify inappropriate utilization and fraud. It will be a national, standard, integrated system that maintains complete beneficiary and provider claims history files. These files will be used to support various post-payment analytic activities including analysis of provider trends and utilization patterns, identification of areas that should be reviewed on a prepayment or postpayment basis, and the investigation of fraud and abuse.

Currently, we are working with our design contractor, GTE Government Systems, and will be phasing-in MTS over a two-year period starting in 1997.

Proactive Steps by Carriers

An example of the efforts to improve communication among carrier medical directors

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began with the new policy of meeting on a regular basis to share information. The medical directors are now developing new local medical policies based on shared information provided by each medical director's own experiences. The medical directors provide input and help make current polices more consistent, which we believe will serve beneficiaries better. Carrier medical directors have also formed small workgroups to develop model policy to help guide carriers in formulating new medical policies and guidelines. Another helpful addition to our information network is the ongoing development of a centralized file of carrier local medical policies that can be easily accessed by all carriers. Now, all local medical policies can be shared and used to improve existing policies and to address problematic issues regarding local medical practices and policies.

Conclusion

The issue of variation in denial rates is complicated and hard to address with one solution. As I stated earlier, variation in denial rates is due to many factors, including variations in local medical practices, development of local medical review policies based on local practice patterns, and varying patterns of fraud and abuse. By recognizing and identifying these causes for variation, we can now focus on ways to make local medical policy more consistent across the nation, work with carriers on identifying ways to reduce aberrancies, and identifying potential patterns of fraud and abuse.

I must emphasize that although variation in local medical practices exist, a preliminary look at the codes used in the draft by the GAO shows that beneficiaries are not adversely affected by the varying denial rates for similar services. We believe that variability in denial rates does not provide a complete picture of the services provided to beneficiaries, nor does it necessarily mean that Medicare beneficiaries and providers from one region to another are treated inequitably. If variation does point to a problem of consistency for beneficiaries and providers, we will most certainly take steps to address the issue immediately.

Through the efforts just described; Medicare is moving forward using new technology to better serve beneficiaries. While we strive to improve our current claims processing system, we are committed to assuring equitable access to covered medical services, treatment and equipment for all beneficiaries.

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